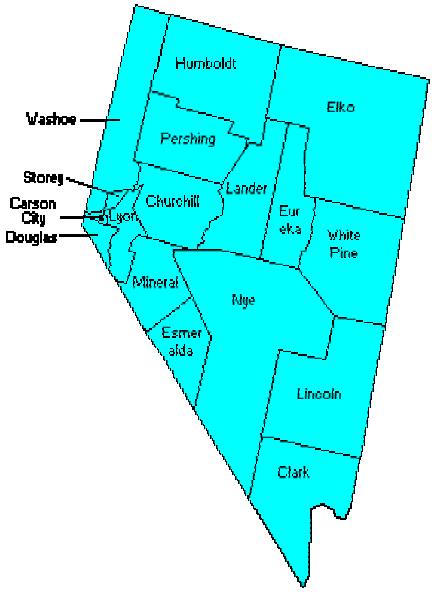
INTRODUCTION

Mental health needs in Nevada are greatly influenced by overall population growth. Nevada is one of the fastest growing states in the union, maintaining an increasing population expansion that has averaged 5.5% per year over the past five years. Reno (Washoe County) and Las Vegas (Clark County) account for an astonishing 85% of the state's population. The remaining 15% of the state's population outside of Washoe and Clark Counties reside in 15 rural counties ranging in population from 1,500 (Esmeralda County) to 53,000 (Carson County), making the state's average population density unusually low at approximately 19 persons per square mile.[1]



Taken together, the urban and rural contrast creates an acutely difficult social environment for persons with special needs such as mental illness who are living in Nevada. Because of the low population density, isolation is a major issue in rural areas. Nevada's small towns are often two to four hours by car to the next settlement, with some even further from the closest major city. This environment poses enormous challenges to agencies and organizations trying to provide any kind of consistent and effective community-based service and social outreach.

The rate of increase in culturally and ethnically diverse populations is three times greater than any other state. Currently, more than 50% of public school students in Clark County are from racial and ethnic backgrounds other than Caucasian. Projections indicate by 2020, approximately 25% of the state's population will be of Hispanic origin, the fastest growing ethnic group in Nevada.[2]

The provision of services is also complicated by high rates of social problems (e.g., ranked #1 in the nation for suicides). For example, the national suicide rate is approximately 13 per 100,000 people for the past eight years (1990 – 1998); whereas, Nevada's suicide rate is approximately 26 per 100,000 people, *double* the national average. There are also high rates of substance abuse.[3] Approximately 10-15% of Nevada residents report some alcohol abuse; more than 2000 males and 300 females are inmates in Nevada state prison systems with "serious alcohol and/or drug problems"; drug and alcohol arrests account for 14% of all juvenile arrests; and alcohol was the major contributing factor to approximately 37.8% of fatal traffic accidents in 2000. Another social problem is the domination of tourism and gaming upon the labor market with low-wage,

[1] Nevada State Demographer, University of Nevada, Reno. www.unr.edu.
[2] Internal statistics. (2001). Carson City: State of Nevada – Department of Education.
[3] Herzik, E (2001) The Nevada Substance Abuse Report 2001, University of Nevada, Reno

service-sector jobs, that creates a socioeconomic environment fostering transience and excessive gambling and drinking.

Since 1996, the Division of Mental Health and Developmental Services (MHDS) has undertaken a biennial assessment of mental health services. The last Needs Assessment occurred in January of 2000. Between FY00 and FY01, many changes have taken place within the Division of MHDS, including the expansion of construction at both Lake's Crossing Center (LCC) to accommodate 48 individuals in needs of forensic mental health services. Another is the completion of the Dini-Townsend Hospital at Northern Nevada Adult Mental Health Services (NNAMHS), renamed from Nevada Mental Health Institute (NMHI). The current hospital was constructed to provide services to 90 persons (80 acute and 10 observation) and is currently staffed for 50. The FY00 Biennial Report[4] describes the programs/services provided by the Division of MHDS, including programs/services initiated as a result of the last Needs Assessment. For copies of this report, please visit our website at mhds.state.nv.us or call the central office at (775) 684-5943.

In 2000, the Division also reviewed and updated its Strategic Plan[5]. The strategy pertaining to the division-wide Needs Assessment was updated to reflect a timeframe so that an assessment occurs every even-numbered year.

Although the format and the forms used to conduct the MHDS Needs Assessment have changed since 1996, the focus has not. Historically, needs assessments focus on utilization of specific services such as training, substance abuse, education, etc. This report represents a global approach for collecting data used to advocate, plan for, and support the development of additional services, to earmark limited resources for services most needed (indicated as a "high priority"), and identify needs/gaps between current and desired results regarding all mental health services and programs.

Besides surveys sent to the various division mental health agencies (Attachment I) and community human service providers (Attachment II), other data sources include, but are not limited to, the following:

Division MHDS Biennial Report (FY 2000)
MHDS General Financial Overview (FY 1998-2001)
MHDS 4th Quarter (FY2001)
Strategic Plan (March 2000)
Agency Director's Report
Division Personnel Vacancy Report
CMHS Block Grant Application for FY00-01
2001 Continuum of Care Applications (Truckee Meadows, Clark County and Rural Nevada)

NOTE: Community information is not available. Approximately 100 community human service agencies were provided with surveys. Of those only one provider responded regarding Washoe County. Rural Clinics Administration included community gaps analysis with their agency data

[4] Division of MHDS Biennial Report (FY2000)
[5] Division of MHDS Strategic Plan (March 2000).

and is included in this report under the section for Rural Clinics. Because of these issues, data analysis of the specific gaps/needs for each community is not included in this report (with the exception of Rural Nevada information).

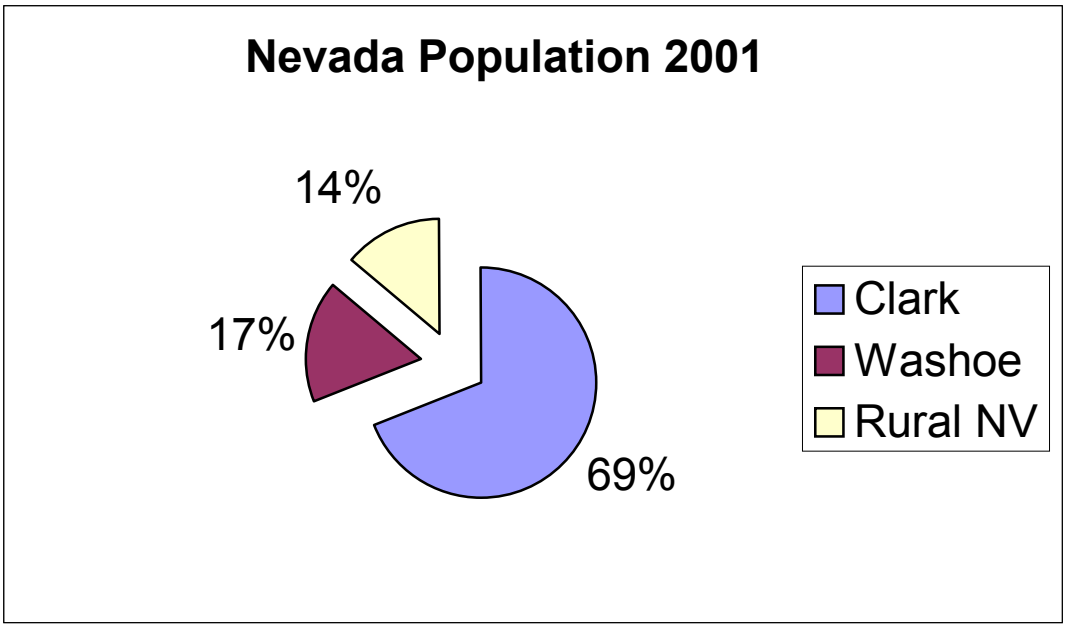
STATE DEMOGRAPHIC INFORMATION

The state of Nevada covers more than 110,000 square miles consisting of two urban areas (Clark and Washoe Counties) and more than 96,000 of rural areas, with population density approximately one person per 15 square miles.

Demographic information used below was obtained from both the Nevada Commission on Economic Development (www.expand2nevada.com) and the State Demographer (www.unr.edu). The website information was updated 04/01. The table below indicates statewide population for the past three years (2000-2002) and should be seen as estimated values:

Area	2000	2001	2002
Clark County	1,375,765	1,491,198 (projected)	1,600,406 (projected)
Washoe County	339,486	336,263 (projected)	346,005 (projected)
Rural Nevada	283,006	321,008 (projected)	327,953 (projected)
State Total	**1,988,257**	**2,148,132 (projected)**	**2,274,364 (projected)**

An approximate percentage of the population can be depicted as follows:



Based on demographic data, each county demonstrates a trend of increasing population, though the overall state trend between FY 00-01 and FY 01-02 is actually less in the latter.

According to website information updated on 04/-01, estimated population totals for 2001 and 2002 by area are:

Area/population by date	2001	2002
Carson City	55,413	56,665
Clark County	1,491,158	No Data
Churchill County	27,195	28,064
Douglas County	44,320	47,955
Elko County	53, 350	54,292
Esmeralda County	1, 546	1,558
Eureka County	1,965	1,982
Humboldt County	18, 419	18,586
Lander County	7, 151	7,222
Lincoln County	4,255	4,258
Lyon County	37, 357	38,897
Mineral County	6, 461	6,390
Nye County	38,969	41,243
Pershing County	8,064	8,313
Storey County	4, 113	4,193
Washoe County	336,263	346,005
White Pine County	10,811	10,647

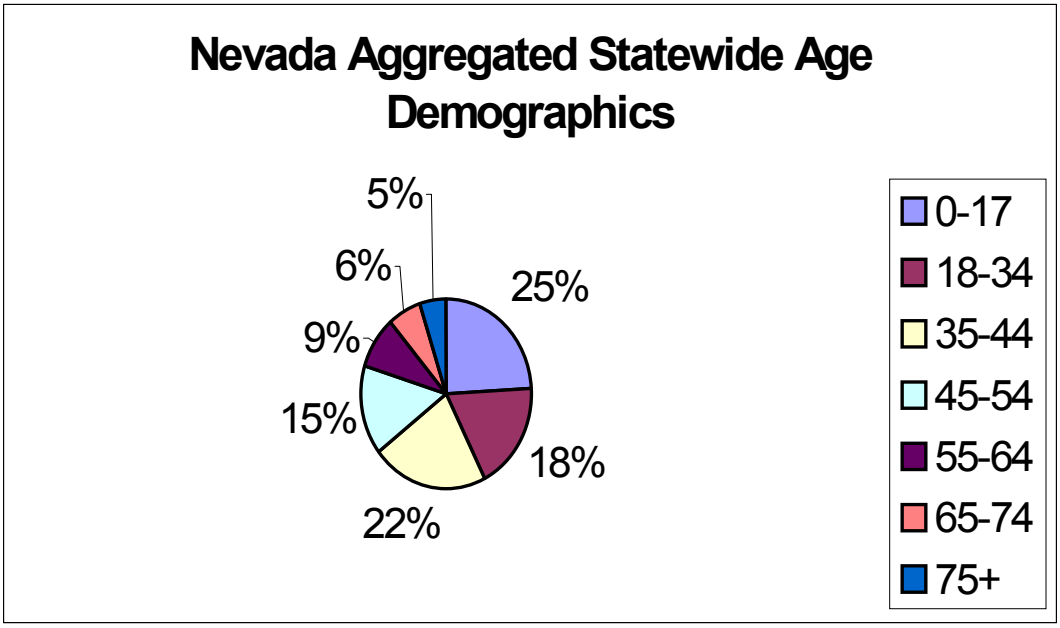
With the exception of Clark County (no data available), the demographic data depicted above also indicate increasing population trends for each of Nevada's individual counties.

According to statistics gathered from the Commission on Economic Commission (website information updated 04/01), age population distribution as a percentage of the area's total population is as follows:

Age/Area	**0-17**	**18-34**	**35-44**	**45-54**	**55-64**	**65-74**	**75+**
Clark County	25%	22.8%	30.7%	N/A	9.2%	7.0%	5.2%
Washoe County	24%	22.8%	32.3%	N/A	9.0%	11.9%	N/A
Douglas County	25.3%	18.2%	33%	N/A	9.5%	8.2%	5.8%
Elko County	31.1%	23.3%	30.2%	30.2%	7.9%	4.4%	3.1%
Carson City	22.5%	21.8%	15.6%	14.3%	9.9%	8.9%	7.0%
Churchill County	27.6%	21.3%	15.3%	17.9%	N/A	11.4%	6.5%
Esmeralda County	23.6%	21%	33.2%	N/A	10.3%	6.7%	5.2%
Eureka County	27.5%	20.3%	32.3%	N/A	9.5%	6.5%	3.9%
Humboldt County	29.8%	23.1%	30%	N/A	8%	5.5%	3.6%
Lander County	32.6%	22.7%	29.7%	N/A	7.8%	4.3%	2.9%
Lincoln County	33.3%	18.9%	22%	N/A	9.1%	8.8%	7.9%
Lyon County	27%	17.9%	14.1%	14.1%	20.3%	N/A	6.6%
Mineral County	29.5%	19.4%	26.6%	N/A	10.3%	7.9%	6.3%
Nye County	25.1%	19.1%	29.8%	N/A	11.7%	8.6%	5.7%
Pershing County	26.8%	21%	26.9%	N/A	8.8%	7.8%	8.7%
Storey County	23%	19.7%	17.1%	17.8%	10.6%	6.8%	5.0%
White Pine	25.9%	23.1%	29.3%	8.9%	N/A	6.8%	6.8%
Aggregated Total	**25%**	**18%**	**22%**	**15%**	**9%**	**6%**	**5%**

As can be seen in the table above, the highest percentage of the population is between 0 and 17 years of age (approximately 25%). The population within the workforce years (18-44) represents

approximately 64% of the total population, with seniors (65 and over) representing approximately 11% of the population. Using the table on the previous page, the graph below depicts the aggregated data:



Based on 2001 demographer data, the distribution of population by race as a percentage of the area's population is as follows:

Area	Clark	Washoe	Rural (Avg.)
White/Caucasian	67.6%	77%	79%
Black/African	9.8%	2.3%	2%
American Indian/Eskimo	0.7%	1.6%	4%
Asian/P. Islander	4.3%	5%	2%
Hispanic	17.5%	14.1%	14%
Other	0.1%	0.1%	0.1%

The Mental Health Block Grant (p.66) estimates the prevalence rate of serious mental illness in Nevada to be approximately 83,048 (5.4% of the total population of Nevada), though population estimates were figured higher – 1,537,929. The Center for Mental Health Services (website) also estimates of those approximate 83,048 people who live in Nevada and may suffer from a serious mental illness, approximately 25% (20,762) will be homeless at any given time during the year. Based on demographic information and prevalence rate of serious mental illness and homelessness, it is possible the Division of MHDS is under serving the following subpopulations:

- Adults of Asian or Hispanic Origin
- Adults who are over the age of 60

- Adults (individuals and persons with family) who are homeless and are of a certain subpopulation of Nevada (seriously mentally ill, co-occurring disorder, domestic violence, etc.)

THE DIVISION OF MHDS (Mental Health and Developmental Services)

The Division of Mental Health and Developmental Services (MHDS) is responsible for the operation of state-funded community mental health programs, inpatient programs, and mental health forensic services. By statute, the Division is responsible for planning and evaluation, administration, policy setting, performance improvement and monitoring and also budget development of all state-funded mental health programs. Division administration is directly involved in all decisions regarding agency structure, staffing, programs/services and budget development. The mission of the Division of MHDS is as follows:

Mission Statement

Working in partnership with consumers, families, advocacy groups, agencies, and diverse communities, the Division of Mental Health and Developmental Services provides responsive services and informed leadership to ensure quality outcomes. The Division's mission includes treatment in the least restrictive environment, prevention, education, habilitation, and rehabilitation for Nevadans challenged with mental illness or mental retardation. These services are designed to maximize each individual's degree of independence, functioning, and satisfaction.

In order to accomplish this mission, one of the goals of the Division of MHDS is to provide comprehensive, state of the art, cost efficient and high quality services which are accessible, available, and responsive to the needs of individuals, families and communities, emphasizing community-based services. In order to accomplish this goal, the division strategy, according to the 2000 Strategic Plan, is to conduct a biennial Needs Assessment. The Performance Improvement team within the Division conducts the biennial Needs Assessment.

According to the MHDS FY00 Biennial Report and the MHDS General Financial Overview[6], the program budgets, positions and caseload for the four mental health agencies over the last three years is as follows:

MHDS DISTRIBUTION					
	1999	2000	**Change**	2001	**Change**
Budget	$52,630,685	$58,469,299	$5,838,614+	$60,516,836	$2,047,537+
Positions	687.45	721.88	34.43+	726.38	4.50+
Caseload	18,523	19,456	933.00+	22,093	2,637.00+

[6] Division of MHDS General Financial Overview 1998-2001 (July 2000).

Within the caseload data, the following is a breakdown of diagnosis at time of admission for both inpatient and outpatient services:

Diagnostic Category	Inpatient	Outpatient
Mood Disorders	48%	35%
Schizophrenia (related)	17%	43%
Substance Related	10%	10%
Adj./Personality	7%	7%
Other Disorders	20%	5%

Due to the Governor's commitment to provide needed services to underserved populations in Nevada, the Department of Human Resources is expected to have the following budget increases[7]:

	FY02	FY03	TOTAL
Community-based	$48,493,569 (68%)	$22, 581,137 (32%)	$71,074,706
Institutional-based	$51,235,607 (68%)	$23,703,846 (32%)	$74,939,453
Increase	$2,742,038 (71%)	$1,122,709 ((29%)	$3,864,747.00

This increase affected medication clinic, service coordination, residential supports and outpatient counseling programs. The legislature also approved funds in excess of the Governor's recommendations in the area of residential supports. The funding was raised from $528,617 in FY02 to $574,733 and from $1,081,702 to $1,271,353 in FY03 (9% increase).

NOTE: According to the 1999 date by the National Association of State Mental Health Program Directors (NASMHPD), Nevada ranks 35th in actual dollars and per capita expenditures and ranks 47th when it comes to the state's per capita expenditures for state hospitals.

CENTRAL OFFICE (MHDS)

DIVISION MHDS ADMINISTRATION

The Nevada Division of Mental Health and Developmental Services (MHDS) is located within the Department of Human Resources and the "central office" is located in Carson City. There are a total of 18 positions with responsibility for overall administration of the continuous operation of each mental health program, organized into three regions: North, South, and Rural. Overall, the administrative staff costs comprise only 2% of the state MHDS budget, while routine administrative costs are generally 3-4 times this amount.

By statute, the scope of authority encompassed by the central office includes administration, planning, management, policy setting, and monitoring of statewide adult mental health services. Besides the Administrator and Deputy Administrator, there are five fiscal accounting positions,

[7] Department of Human Resources Budget Highlights (August 2001).

four support staff positions, one Developmental Services position, two Personnel positions and the other five positions are responsible for the functions of planning and evaluation as well as performance improvement and monitoring.

Central office is directly responsible for specifying and implementing data collection requirements, performance monitoring, the statewide management information system, computer system, quality assurance, program planning and budgeting, and identifying critical unmet infrastructure needs as part of any statewide MH needs. Overall, the infrastructure gaps seen in the central office reflect substantially increased need for statewide consistency in the MH programs as offered by the agencies.

Specific unmet needs for the division central office include:

- **Adequate statewide training resources**: Currently the division relies on an existing staff member who devotes less than 10% of their time to division training within additional responsibility for residential services in an off-site agency. Each agency maintains a training budget for agency specific training[8] (e.g., certification, sexual harassment, abuse and neglect, etc.). During the FY02/03 biennium, the division was allotted $10,000 for the training of approximately 1,250 employees, which is less than $8.00 per staff/per year. This amount does not adequately address the training needs necessary to maintain competency in such required areas as policies/procedures, information technology, administrative protocols, confidentiality (HIPAA), treatment planning, etc.

- **Statewide Accreditation of mental health agencies.** Review of agency sections illustrates needs at each agency to initiate or maintain national accreditation. There are two primary national accreditation agencies: (a) the Joint Commission on Accreditation of Health Care Organizations (JCAHO), which focuses on in-patient and community mental health agencies, and (b) the Council on Accreditation of Rehabilitation Facilities (CARF), which is focused on rural and forensic facilities. A strong statewide accreditation system employing both JCAHO and CARF standards are new responsibilities that are currently gaps not only for each agency, but also to the central office. Therefore, resources are needed for both the central office and each of its contractual agencies. Another identified gap involves the need for MHDS to be able to participate as a member of the Western States Commission of Higher Education (WICHE). An unmet infrastructure need is evident as Nevada has not been afforded funding such that MHDS can provide reimbursement of its membership fees charged to each western state. This gap has similarly resulted in lack of regional and interstate coordination of Nevada's mental health programs.

- **MHDS Management of Information Software (MIS) replacement/upgrade**

In February 2001 Creative Socio-Medics Corp. (CSM) acquired the intellectual property of Advanced Institutional Management Software (AIMS), the system currently used for management of mental health information. Therefore Nevada's mental health data infrastructure must now plan for the immediate discontinuation of the AIMS software due to corporate mergers beyond the control of the Nevada MHSA.

[8] Division of MHDS Quarterly Training Report (July 2001-September 2001)

The AIMS system provides information about client intake, discharge and census, as well as program tracking, billing, accounts receivable and pharmacy functions with approximately 225 terminals and personal computers (PC) linked to the AS/400 across the regions. Thirteen FTE are assigned to program evaluation and management information system functions.

CSM will also track the above information and is HIPAA compliant.

The Division of MHDS applied for and received funding for a $300,000 3-year Data Infrastructure Grant (DIG) in 2001. The grant provides $100,000 in funds each year with a state match of $50,000. The DIG indicates the following improvements to the MIS system:

- A single point of response for all maintenance and support activity, for both AIMS and the new contractor's applications
- A MIS that will ensure the long-term viability of the contractor and guarantees ongoing product and implementation support
- MHDS will seek a contractor which expands its State User Association, offering a critical mass that is expected to impact data initiatives at the federal level and provides expanded peer support to the users
- A MIS that will provide a technology growth path that will ensure product development and enhancements now and into the near future, standardized around a single-system design

The Division will continue to use DIG funds to systematically phase in the new MIS over the next 24 months, which maintains the following goals:

- Assure accurate reporting ob BASIC and DEVELOPMENTAL Center for Mental health Services (CMHS) Block Grant Indicators
- Involvement of the Division of MHDS staff in national mental health statistical improvement activities

The Division of MHDS continues to have the need to construct a statewide MIS that can:

- ✓ be available to all clinicians and clinics;
- ✓ include full client trust funds accounting, pharmacy components;
- ✓ encompass the developmental service agencies and programs

- **Disaster preparedness (biological weapons of mass destruction)**

A critical unmet need, which has markedly impacted Nevada's public mental health and related health care facilities, is the responsibility to respond to the deployment of weapons of mass destruction (including those of a biological nature). This could include preparation for large-scale use of smallpox, tularemia, pneumonic plague, anthrax, and other biological and nerve agents.

MHDS is seeking funding to continue and enhance the Division's Disaster Response Program. Beginning in 1998 with a two-year FEMA grant, the Division of MHDS has developed a Disaster Preparedness Program and plan for its agencies. In case of major declared disaster, the Division of MHDS has the following statewide responsibilities during officially declared disasters:

- Enact regional emergency response cells during declared bio-terrorism disasters
- Enact Carson City Division office emergency response cell during declared bio-terrorism disasters
- Cooperate with all local state and federal bio-terrorism agencies to minimize the loss of life and property
- Maintain services to the individuals who receive our services
- Provide/coordinate crisis counseling and related mental health outreach services to survivors of the bio-terrorism disasters
- Maintain and access a listing of community volunteers who are mental health professionals to arrange for bio-terrorism crisis counseling services
- Arrange for maximal use of the division's facilities during declared disasters

MHDS needs to complete the work started in 1998 by putting in place a rudimentary response capacity and expanding available trained personnel to operationalize the MHDS Disaster Response Plan to include bio-terrorism events. This will require personnel statewide to participate in an enhanced public health alert network, FEMA trainings, emergency communications, and bio-terrorism symptom and information reporting.

● Statewide peer-specialist program

Since the mid 1990's, the Nevada Division of MHDS has been interested in hiring peer counselors as part of transitional mental health services available. These positions are necessary in developing activities such as work and career transitional skills, mentoring of recently discharged clients, assisting the development and use of consumer satisfaction surveys, assisting and advising the Division regarding program quality assurance efforts, and designing statewide consumer advocacy and policy development efforts (e.g., a human rights board to review client care complaints). The Peer Specialist series was also designed to provide promotional career opportunities into other permanent State positions.

Using federal CMHS funds, MHDS positioned six new Peer Counselors in May, 2002. They are placed as follows:
- Three at Southern Nevada Adult Mental Health Services (SNAMHS)
- Two at the Northern Nevada Adult Mental Health Services (NNAMHS)
- One at Rural Clinics (Douglas Co. Clinic)

Central office has identified a clear unmet need and desires to strengthen the consumer support infrastructure by addressing the unmet need in the peer specialist programs. We intend to complete the infrastructure of this program by matching existing federal dollars, and then leveraging these new state dollars using a 50% Medicaid match such that MHDS can employ six additional peer counselors across the state.

● Statewide coordination of programs/services that assist consumers who have mental illness (including co-occurring substance use disorder) and are homeless

Over the past several years the Division of MHDS has agreed with federal research regarding the important role housing programs play in stabilization and community integration of persons with

mental illnesses. Currently, there are partnership projects underway among various local, state, and federal government agencies as well as non-profit service providers, consumers, and family members.

One project is the yearly Continuum of Care (CoC) applications to Housing and Urban Development (HUD). Continuum of Care is "a community plan to organize and deliver housing and services to meet the specific needs of people who are homeless as they move to stable housing and maximum self-sufficiency."[9] The various components of a CoC are:

- ✓ Outreach, intake, assessment
- ✓ Emergency shelter
- ✓ Transitional housing
- ✓ Permanent housing
- ✓ Permanent supportive housing
- ✓ Supportive services

The other project is the Policy Academy for state and local policymakers: improving access to mainstream services for persons who are homeless: focus on homeless families with children." The objectives of the academy are:

- ✓ Help states build teams and a sense of common vision, goals and priorities
- ✓ Identify key areas where the state team may desire technical assistance
- ✓ Prepare the state team to come to the Policy Academy poised to move into an action-planning mode

The "State of Nevada Team" met in New Mexico November 26-29th. From that meeting they developed the following priorities:

- ✓ Develop and communicate relevant data for decision makers to use in crafting policy
- ✓ Ensure services are coordinated effectively so that clients move through a seamless continuum of care
- ✓ Compile inventory of entire range of housing programs and compare to needs identified in needs assessment
- ✓ Ensure those who are vulnerable do not fall into homelessness
- ✓ Ensure homeless persons are able to achieve the highest possible level of self-sufficiency
- ✓ Evoke public interest in addressing homelessness as a public policy issue

To address the various objectives, goals, priorities, etc. a position should be created to ensure coordination of effort, supervision of responsibilities, grant oversight, and program/service development.

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[9] HUD Guide to Continuum of Care Planning and Implementation

AGENCY SERVICE INFORMATION

Generally, mental health services are provided by governmental agencies (SNAMHS, NNAMHS, and Rural Clinics) for specific geographical regions and will therefore be discussed separately. Four agencies deliver adult mental health services: three comprehensive mental health centers and one forensic facility. The directors of these agencies are appointed by and report directly to the Administrator of MHDS.

NOTE:
A Needs Assessment Survey was sent out to each Agency Directors. Information used for data analysis was obtained from the survey as well as those mentioned above in the executive summary.

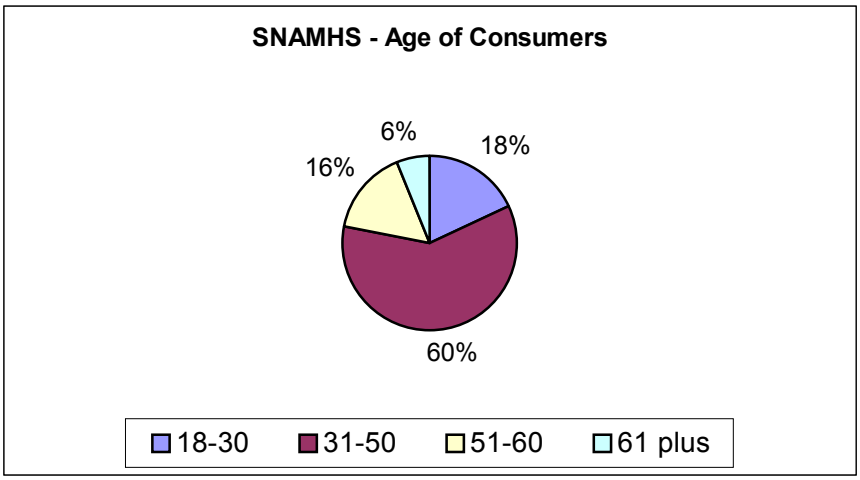
SNAMHS – CLARK COUNTY

Southern Nevada Adult Mental Health Services – The main SNAMHS campus at 6161 West Charleston provides inpatient and outpatient services to Clark County including the greater metropolitan area of Las Vegas. There are also satellite offices in North Las Vegas, Henderson, and East Las Vegas. The mission of SNAMHS is to help adults (persons 18 and older) with mental illness, through the provision of inpatient and community-based services, empowering them to live safely and participate in the community, improving their quality of life. To accomplish this mission, SNAMHS provides the following services/programs:

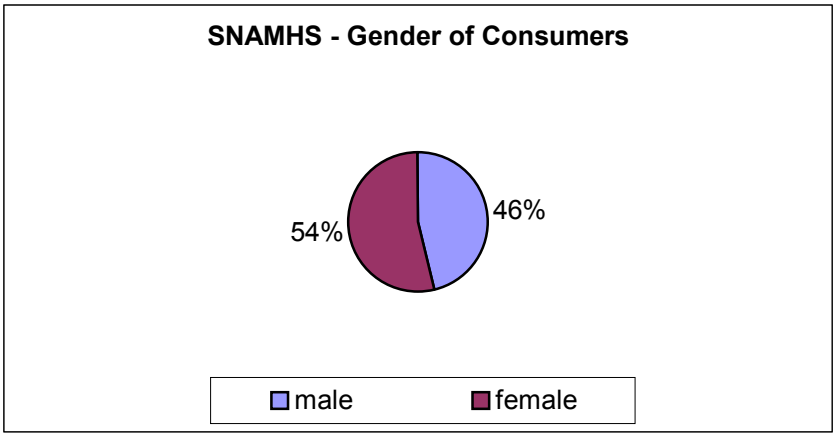
Inpatient Services	Psychiatric Emergency Services	Residential Supports
Medication Clinic	Outpatient Counseling	Service Coordination
Geriatric Services	Psychosocial Rehabilitation	PACT
Contractual Services		

The FY01 budget for SNAMHS was $30,267,071 and the end-of-year caseload was 11,528; approximately 45% of which were diagnosed as Severely Mentally Ill (SMI). The *approximate* demographic information available for the population served is as follows:

AGE: 18-30 (18%) 31-50 (60%)
51-60 (16%) 61 and older (6%)

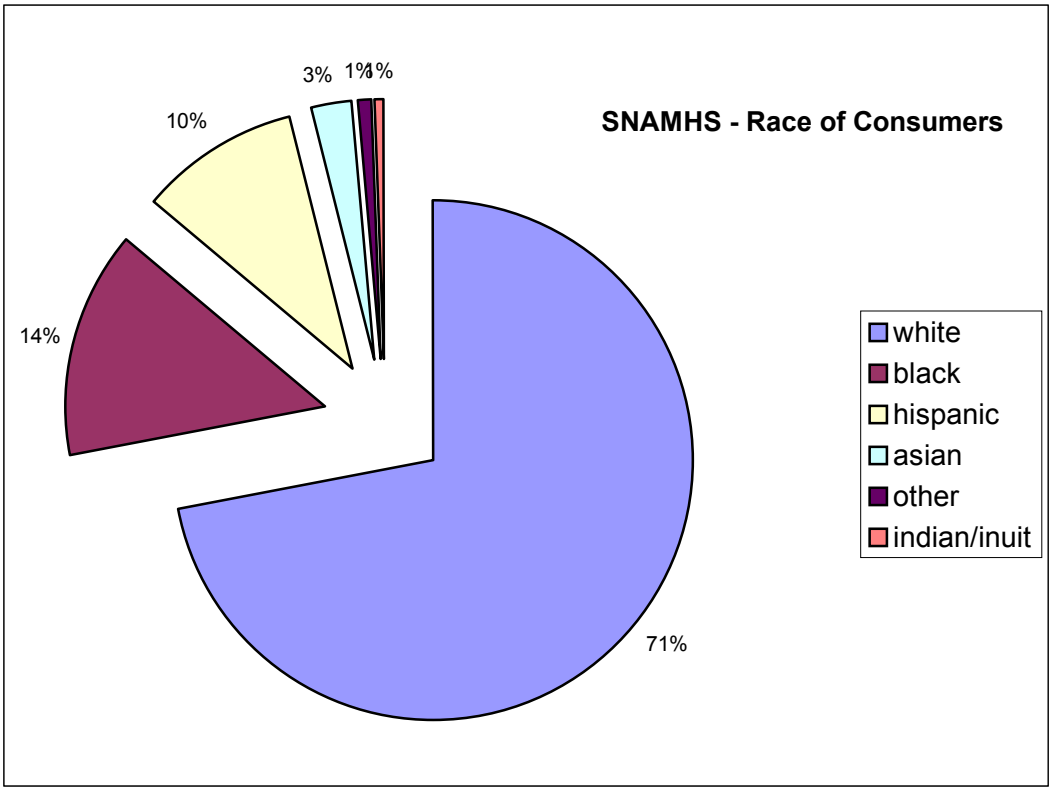


GENDER: Male (46%) Female (54%)



RACE/ETHNICITY:

White (72%)	Black/African Amer. (14%)
Hispanic/Latino (10%)	Asian/Pac Islander (2.5%)
Other (1%)	Indian/Alaskan (.5%)



At the end of July 2001, there were 274.5 positions filled and 38.25 positions vacant (14% vacancy rate). According to Division Personnel information, the majority of positions were direct-care clinical staff (77%). Positions with a vacancy rate exceeding 10% are:

- Psychiatrist 11%
- Nurse 14%
- Mental Health Tech. 17%

SNAMHS Personnel will have additional information regarding agency staff vacancies.

PROGRAM/SERVICES DATA–

INPATIENT PROGRAM: Provides acute and some long-term care for adults with mental illness, including seniors. Continuity of care is provided through release planning, psychosocial rehabilitation, transitional living, and a full range of outpatient services.

The June census was 82, 67 of which were SMI (MHDS 4th Quarter, FY2001, p.17). According to the Needs Assessment Survey, a total of 1,442 people were provided services as the end of FY01. There was an unmet need/gap of approximately 237 and this service was deemed a "high priority."

Over the next biennium SNAMHS will achieve accreditation by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). In order to achieve accreditation, a number of new positions will be required to meet standards of care expected by JCAHO.

PSYCHIATRIC EMERGENCY SERVICES (PES): This service, provided at 6161 West Charleston consists of two programs as follows:

> ***A***. *Ambulatory Unit*: The ambulatory unit provides crisis assessment and intervention services. Programs consist of psychiatric inpatient/outpatient programs, observation units, alcohol/drug programs, crisis/medication counseling, and works with other community agencies in and outside of Clark County.

According to the Needs Assessment Survey, the ambulatory unit served 5,101 individuals in FY01, though 1,362 additional individuals remained who required services.

> ***B***. *Observation Unit*: The observation unit also provides services in Clark County. A limited variety of services are offered including emergency services, voluntary admissions, court-committed assessment/intervention, and court-ordered services.

The staff capacity is 10 persons and the average number of clients served per day was 12.7 persons in FY01 (MHDS 4th Quarter, p.23). During the past year, the observation unit served 2,855 with a remaining need of 816 individuals who required services. A new capital improvement project is underway to expand the capacity from 10 to 30 beds. In order to accomplish this expansion, additional staff will be needed.

SNAMHS would also like to pilot a Mobile Crisis Unit that will coordinate services with local emergency rooms. This unit would assess the mental health needs of those individuals who are currently being kept in the emergency rooms for extended times awaiting determination. In order to accomplish this, the agency will need an additional 5.6 FTE (Psychiatric Registered Nurse II and Clinical Social Worker II). Equipment will also be needed for this endeavor, including one state motor pool vehicle and one cellular phone.

RESIDENTIAL SUPPORTS: Provides an array of residential services to best meet the needs and the goals of the individual. All residential services are provided by independent contractors. The June census indicated that 195 persons were being provided residential supports, all of which were SMI (MHDS 4th Quarter, pps.29-36). The Needs Assessment Survey provided the following information for Residential Supports:

SNAMHS Residential Supports			
Type of Service	Caseload	**Unmet Need/Gap**	Priority
SLA/SPC	279	27	High
Group Home	641	37	High
Specialized Residential Services	54	0	Low
TOTAL	**974**	**64**	

There were approximately 24 people waiting to receive residential supports as of 7/01 (Agency Director's Report). The Needs Assessment Survey indicated an additional unmet need/gap of 64 and, with the exception of specialized residential support (e.g. BART), this service was a "high priority" for the agency.

In conjunction with the national trend of decreasing group home placements toward Supported Living Arrangement (SLAs) and Intensive Supported Living Arrangements (ISLAs), an additional 64 SLA and 8 ISLA placements, using residential support funds, will be included in the next agency budget.

In addition to the placements, one Activity Therapist needs to be assigned to Residential Support Services in order to provide training and consultation to the group home and SLA providers who provide support to approximately 500 consumers of residential support programs.

MEDICATION CLINIC: Provides outpatient adult psychiatric nursing and direct medication services, including prescribing and dispensing both injectable and oral medication. Services include consultation with each consumer about psychiatric medication treatment and referrals to other agencies.

The June census was 5,247, 2,300 of which were SMI (MHDS 4th Quarter FY2001, p.25). According to the Needs Assessment survey, the caseload for FY01 was 8,717 and the unmet need/gap was 717. This service was a "high priority" for the agency.

Medication clinic services are provided at 4 separate site offices in Clark County (West Charleston, Henderson, East Las Vegas and North Las Vegas). Currently there is one supervisory nurse at the West Charleston office who is responsible for supervising the Psychiatric Ambulatory Services side of the Psychiatric Emergency Services Department. Given the enormous increase in demand for medication clinic and emergency services, a formal request to upgrade the Psychiatric Registered Nurse II positions (one for each site) to a grade III was submitted to State Personnel as is waiting for approval.

OUTPATIENT COUNSELING: Provides diagnosis and evaluation, counseling, psychotherapy, and behavioral management at each of the four sites. These programs focus on developing insight, producing cognitive/behavioral change, improving decision-making, and/or reducing stress. Specialized services are provided to families and couples. Group counseling sessions include activity therapy as well as psychotherapy.

The Licensed Clinical Psychologists are the only staff in this department who may diagnose consumers. With the exception of the Henderson office, there are no Licensed Clinical Psychologists on staff and, therefore are needed.

The June census was 1110, 422 of which were diagnosed as SMI (MHDS 4th Quarter, p.26). According to the Needs Assessment Survey, 2,836 persons were provided outpatient counseling and an unmet need/gap of 120 remained as of the end of FY01. This service was a "high priority" for the agency.

SERVICE COORDINATION: Provides coordination of treatment by assisting individuals to access financial, housing, medical, employment, social, transportation, crisis intervention, entitlement programs (food stamps, SSI, etc.), and other essential community resources as indicated on the consumer's treatment plan. Programs such as Service Coordination also help mobilize family, community and self-help groups on the behalf of the consumer.

The June census was 582, all of which was diagnosed as SMI (MHDS 4th Quarter, p.27). According to the Needs Assessment Survey, a total of 1,096 persons were provided this service and an unmet need/gap 69 remained as of the end of FY01. This service was a "high priority" for the agency.

Intensive Service Coordination is a specialized "unit" within the service coordination department. The unit consists of a team of psychiatric Case Worker II's that serve severely mentally ill individuals who have also been convicted of felony offenses. The ratio of staff to clients is 1:15. Currently there is a waiting list of 28 persons therefore an additional two PCWII positions are needed.

SENIOR MENTAL HEALTH OUTREACH PROGRAM (Attachment III is the brochure regarding this program): Provides services to older adults (age 60+) who are experiencing symptoms of mental illness. Services funded through a federal Title III grant are available in the southern areas including Las Vegas, North Las Vegas, Henderson and Boulder City and will soon be available in the north (Washoe County). The primary goal is to identify, evaluate and provide effective mental health care through community outreach to those in need. Besides an Administrative Assistant, there is one Clinical Social Worker who provides full time direct care services to seniors. Another Clinical Social Worker is the Program Director and is responsible for delivering direct care services to seniors, grant writing and programmatic development, conducting community trainings, participating on several statewide aging coalitions as well as providing clinical consultations to professionals and family members of older adults. In coordination with the Division for Aging Services, this Program is in the process of being expanded through an Independent Living Grant to include a Mental Health Counselor in southern Nevada and a Clinical Social Worker and Administrative Assistant in northern Nevada Both clinical positions will provide full time direct care services to community seniors.

The Needs Assessment Survey indicated that 75 persons had been provided this service, with an end of year census of 59. The Survey indicated 21 people were waiting to receive services from the Senior Mental Health Outreach Program in southern Nevada. As a result of the successfully obtaining additional grant funding the needs of this Program have currently been met and was indicated as a "low priority".

PSYCHOSOCIAL REHABILITATION: Assists consumers in education, employment, social relationships, living situations, leisure lifestyle, and wellness. Services are designed to teach and reinforce functional, adaptive, independent living, social and vocational skills with an emphasis on preparing for and maintaining employment or other self-fulfilling, productive activities.

The June census was 93, all of which were diagnosed as SMI (MHDS 4th Quarter, p.28). 154 individuals were served during the past year, though 65 additional individuals required services (Needs Assessment Survey). This service was a "medium priority" for the agency.
There are currently three Rehabilitation Counselors serving this population across the four site offices. An additional Rehabilitation Counselor is needed so that there is one staff person at each site.

PROGRAM FOR ASSERTIVE COMMUNITY TREATMENT (PACT): Provides a specialized, multi-disciplinary team approach to service coordination. The focus of this team is to elevate the level of functioning and afford a better quality of life. PACT is mobile and services are provided wherever needed.

The June census was 66, all of which were diagnosed as SMI (MHDS 4th Quarter, p.24). This service is typically staffed for 72 individuals however, for the past several months there has been one less PCWII position due to extended medical leave and not being able to hire a replacement for that position. NOTE: In March 2002 the census was 70. During this past year, services were provided to 116 individuals, though there was an unmet need/gap of 7 (Needs Assessment Survey). This was deemed a "medium priority" for the agency.

Each member of the PACT team currently carries a caseload of 12, however the national average is 1:8. Therefore additional staff is needed in order to decrease the caseload to ten (ratio 1:10). Additional staff is needed because of the increased census of the inpatient unit and the ability of the PACT team to provide intensive services and reduce hospital days.

NOTE: SNAMHS administration also mentioned other pressing needs not captured in the survey and were included as an additional sheet. They include:

1. A Privacy Officer, mandated by new HIPAA regulations
2. Agency Medical Director
3. Adequate psychiatric service in community
4. Enlarged PES
5. Mobile Crisis Team
6. Coordinated services for homeless/indigent
7. Medical and dental care
8. Caseload growth
9. Pharmacy coverage

OTHER SERVICES:

SNAMHS has a Memorandum of Understanding (MOU) with Mojave Mental Health. Mojave is a for-profit agency that only provides services to those consumers who are Medicaid-eligible and who are referred by SNAMHS. Services provided by Mojave include:

Outpatient Counseling	Medication Clinic
Service Coordination	Adult Group Counseling (Psych. Rehab.)

The Needs Assessment Survey provided the following information:

TABLE 7. CASELOAD DATA – MOJAVE		
SERVICES	**SERVED**	**NEED**
OUTPATIENT COUNSELING	523	47
ADULT GROUP COUNSELING	239	14
MEDICATION CLINIC	1310	74
SERVICE COORDINATION	795	73
TOTAL	**2867**	**208**

As can be seen by the table above, Medication Clinic and Service Coordination services are the most widely utilized services by Medicaid-eligible people. Mojave served a total of 2,566 individuals during the 2001-2002 year, though a remaining need of 1,942 individuals exist.

SNAMHS contracts with the Salvation Army (non-profit provider), which helps provide a variety of services to people who are homeless and have mental health and/or substance abuse issues. Services include:

- Transitional Living
- Substance Abuse Treatment
- Vocational Services

The Salvation Army is also a Projects for Assistance in Transition from Homelessness (PATH) provider and coordinates with SNAMHS, their mental health liaison agency. Last year, the Salvation Army received $209,100 to provide services to Clark County (including Mesquite) and Pahrump. With this money, they provided the following services:

Outreach (9,561)	PATH-enrolled clients (604)	Screening/diagnostic (444)
Hab./rehab. (604)	Community mental health (604)	Alcohol/drug treatment (311)
Service coord. (604)	Housing services (290)	Basic needs 604)

NNAMHS – WASHOE COUNTY

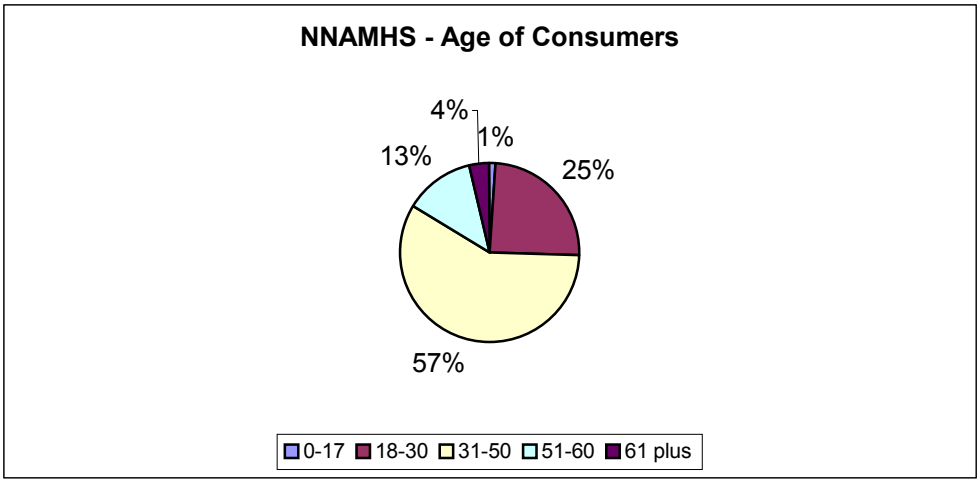
Northern Nevada Adult Mental Health Services (NNAMHS), according to the Mental Health Block Grant (p.40), provides inpatient services and community-based outpatient services via Washoe Community Outpatient Services (WCOS). The mission of NNAMHS is to provide psychiatric treatment and rehabilitation services in the least restrictive setting to support personal recovery and enhance quality of life.

As well as maintaining licensure and certification, NNAMHS is the only psychiatric inpatient hospital currently accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). NNAMHS provides the following programs:

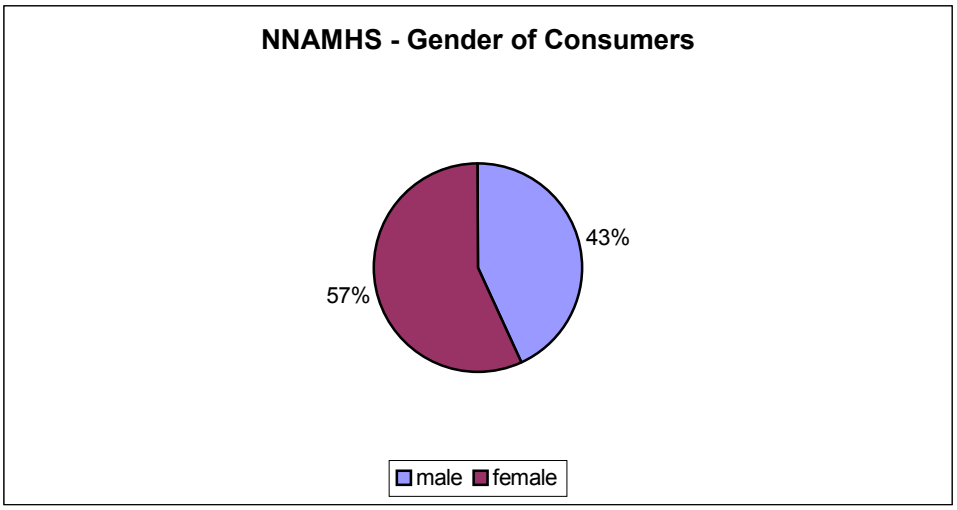
Inpatient Services	Psych. Emergency Services	Medication Clinic
Service Coordination	Residential Supports	Psychosocial Rehabilitation
Outpatient Counseling	PACT	Contractual Services

NNAMHS FY01 budget was $18,055,735 and the end-of-year caseload was 4,022; approximately 45% of whom were diagnosed as SMI. The *approximate* demographic information available for the population served is as follows:

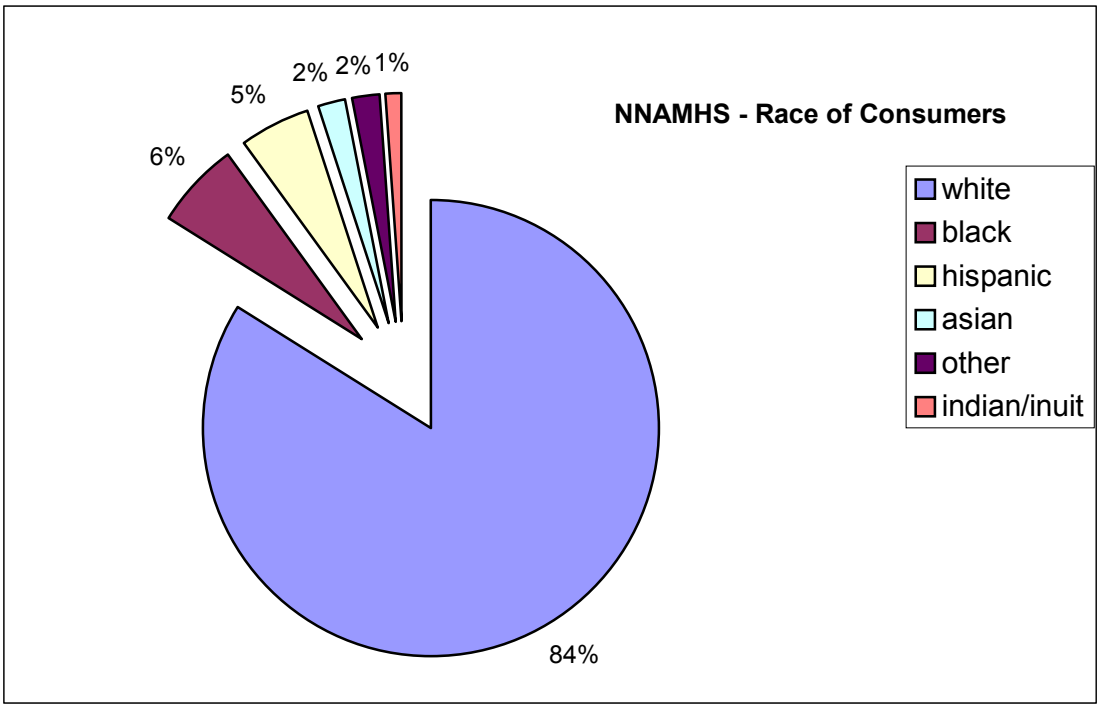
AGE: 0-17 (1%) 18-30 (24.5%) 31-50 (58%) 51-60 (13%) 61+ (3.5%)



GENDER: Male (43%) Female (57%)



RACE/ETHNICITY: White (84%) Black/African Amer. (6%)
Hispanic/Latino (5%) Asian/Pac Islander (2%)
Other (2%) Indian/Alaskan (1%)



As of the end of July 2001, there were 206 positions filled (not including psychiatrists) and 23 positions vacant (not including psychiatrists). According to Division Personnel information, the majority of positions were direct-care clinical staff (59%), with as many as six Mental Health Technician vacancies (May 01).

PROGRAMS/SERVICES DATA –

INPATIENT SERVICES: Provides acute and limited long-term care for adults with mental illness, including seniors. Continuity of care is provided through release planning, psychosocial rehabilitation, transitional living, and a full range of outpatient services (Division Policy and Procedure Manual).

With an average staff capacity of 51, the June census was 39, 30 of which were SMI (MHDS 4th Quarter, FY2001, pps.17-19). As of the end of FY01, a total of 409 people were provided services and there were no unmet needs/gaps indicated in the Needs Assessment Survey.

PSYCHIATRIC EMERGENCY SERVICES: Services available on a 24-hour, 7-day basis and includes assessment/intervention for individuals experiencing crisis. The site also includes observation units for patients requiring extended stays.

With a staff capacity to serve 10 persons, the average caseload was 13 and the end of June census was 4, all of which were diagnosed as SMI (MHDS 4th Quarter, pps.22-23). As of the

end of FY01, 1,683 individuals were provided with this service. The agency reported no unmet need/gaps but indicated this service was a "high priority" (Needs Assessment Survey).

MEDICATION CLINIC: Provides physician visits, or visits by other qualified personnel, for the purpose of prescribing medication, medication refills, dosage regulation, and/or lab work necessary for monitoring consumer health and education.

The June census was 1,509 persons, 829 were diagnosed as SMI (MHDS 4th Quarter, p.25). As of the end of FY01, 2,163 individuals were provided this service. Although no additional need is specified, staff in the medication clinic are experiencing extremely high workloads, which has led to staff burnout and turnover. If the current trends continue, staffing this program will continue to be an increasingly problematic issue. In addition, the implementation of a Mental Health Court in Washoe County will impact this program. Individuals referred to the court will require psychiatric assessments as well as treatment and medication management. Although the extent of the impact in terms of increased service demand is unclear at this time, the court demands on the program will place an increasing burden on existing staff. Therefore this service is a "high priority."

SERVICE COORDINATION: Provides coordination of treatment by assisting individuals to access financial, housing, medical, employment, social, transportation, crisis intervention, entitlement programs (e.g., food stamps, SSI, etc.), and other essential community resources as indicated on the consumer's treatment plan. Service Coordinators also help mobilize family, community and self-help groups on behalf of the consumer.

The June census was 550 of which 417 were diagnosed as SMI (MHDS 4th Quarter, p.27). The agency reported 2,674 individuals were provided services as of the end of FY01 and there were no unmet needs/gaps. This service is a "high priority" for the agency (Needs Assessment Survey).

RESIDENTIAL SUPPORTS: Provides an array of residential services to best meet the needs and goals of the individual. All residential services are independent contractors. Attachment IV contains copies of brochures describing this service. In June (FY01) there were 78 persons being served with residential supports, 62 of which were diagnosed as SMI (MHDS 4th Quarter, pps.29-30). According to the Needs Assessment Survey the caseload data, unmet need/gap and priority for this service were as follows:

TABLE 9. RESIDENTIAL SUPPORTS – NNAMHS

TYPE OF SERVICE	CASELOAD	UNMET NEED/GAP	PRIORITY
TRANSITIONAL HOUSING	65	20	High
PERMANENT HOUSING (SLA, S+C)	132	50	High
GROUP HOME	142	0	High
RTP/RESPITE	48	15	High
TOTAL	**387**	**85**	

PSYCHOSOCIAL REHABILITATION: Assists clients in education, employment, social relationships, living situations, leisure lifestyle, and wellness. According to their brochure (Brochure available upon request), "services are designed to teach and reinforce functional,

adaptive, independent living, social and vocational skills with an emphasis on preparing for and maintaining employment or other self-fulfilling, productive activities." Types of services provided include:

Living Skills Classes Vocational Services Drop-In Center

The June census was 195 with 144 diagnosed as SMI (MHDS 4th Quarter, p. 28). According to the Needs Assessment Survey, there were 114 people were admitted into this service by the end of FY01. The agency had a remaining need of 25 individuals and therefore indicated this service was a "high priority."

OUTPATIENT COUNSELING: Provides counseling on an individual, family, or group basis. These services may include diagnosis and evaluation, counseling, psychotherapy, behavioral management for the purpose of producing cognitive/behavioral change, improving decision-making, and/or reducing stress.

The June census was 379 with 146 diagnosed as SMI (MHDS 4th Quarter, p.26). As of the end of FY01, 674 individuals received community outpatient services and there were no reported needs/gaps (Needs Assessment Survey), though the agency indicated this was a "medium priority."

PROGRAM FOR ASSERTIVE COMMUNITY TREATMENT (PACT): Provides a specialized, multi-disciplinary team approach to Service Coordination. The focus of this team is to elevate the level of functioning and provide a better quality of life. PACT is mobile and services are provided where necessary. Currently this service is provided at a ratio of 1-12, however, the agency and the Division of MHDS would like to align caseloads with other PACT teams across the nation at 1-10.

The June census was 46 with 43 were diagnosed as SMI (MHDS 4th Quarter, p.24). As of the end of FY01, 161 individuals received services with an unmet need/gap of 92 (Needs Assessment Survey) and the agency indicated this was a "high priority."

OTHER SERVICES: NNAMHS has a contractual relationship with ReStart, a non-profit service organization. The contract indicates NNAMHS will pay ReStart between $3,782-$7,564 (1-2 service coordinators) to provide service coordination to 15-50 severely mentally ill persons in the criminal justice system, under the jurisdiction of the Mental Health Court. These individuals are usually serial misdemeanants, mentally ill and treatment resistant. Working with the Mental Health Court and NNAMHS, ReStart staff will develop comprehensive service plans for clients and monitor each client's progress while in treatment. ReStart will provide periodic client progress reports to the court and NNAMHS, which will also include the services provided to each client.

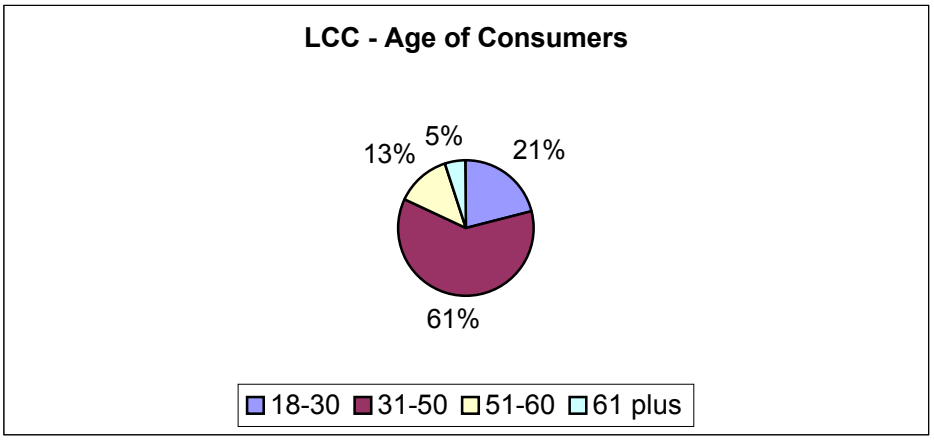
In addition, ReStart provides a variety of services to people who are homeless and have mental health and/or substance abuse issues by providing pass-through PATH funds. This last year, ReStart was awarded $81,000 to provide the following services in Washoe County:

Outreach (2,128)	PATH-enrolled clients (146)	Screening/diagnostic (146)
Hab./rehab. (146)	Community mental health (79)	Alcohol/drug treatment (54)
Service coord. (146)	Housing services (146)	Basic needs (3)

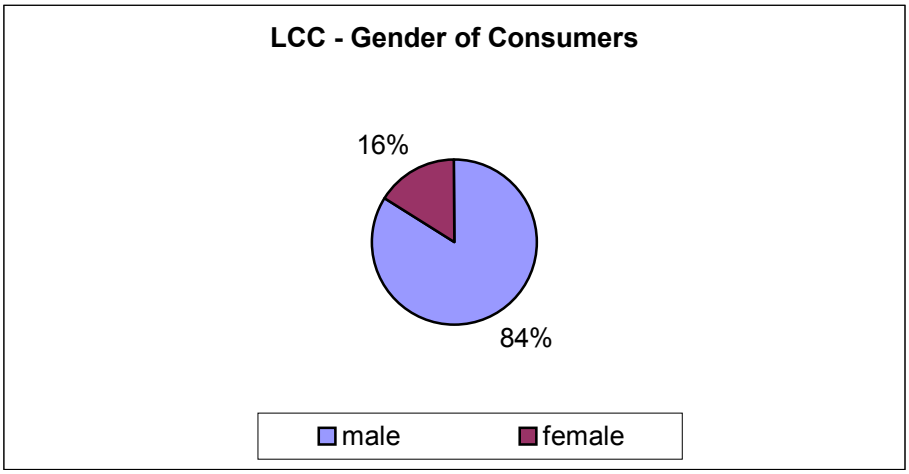
LAKES CROSSING CENTER (LCC)

Washoe County is also the location of the state's only forensic services facility, located on the NNAMHS campus. Mentally disordered offenders are referred to Lake's Crossing Center from throughout the state's various courts to establish competency to stand trial or for initial competency evaluations. LCC also provides mental health services for Clark County Detention Center, Las Vegas City Jail, and Washoe County Jail. As of the end of FY01, there were approximately 161 who received services at this specialized facility. The FY01 budget was $5,019,414. The *approximate* demographic information available for the population served is found on the following two pages:

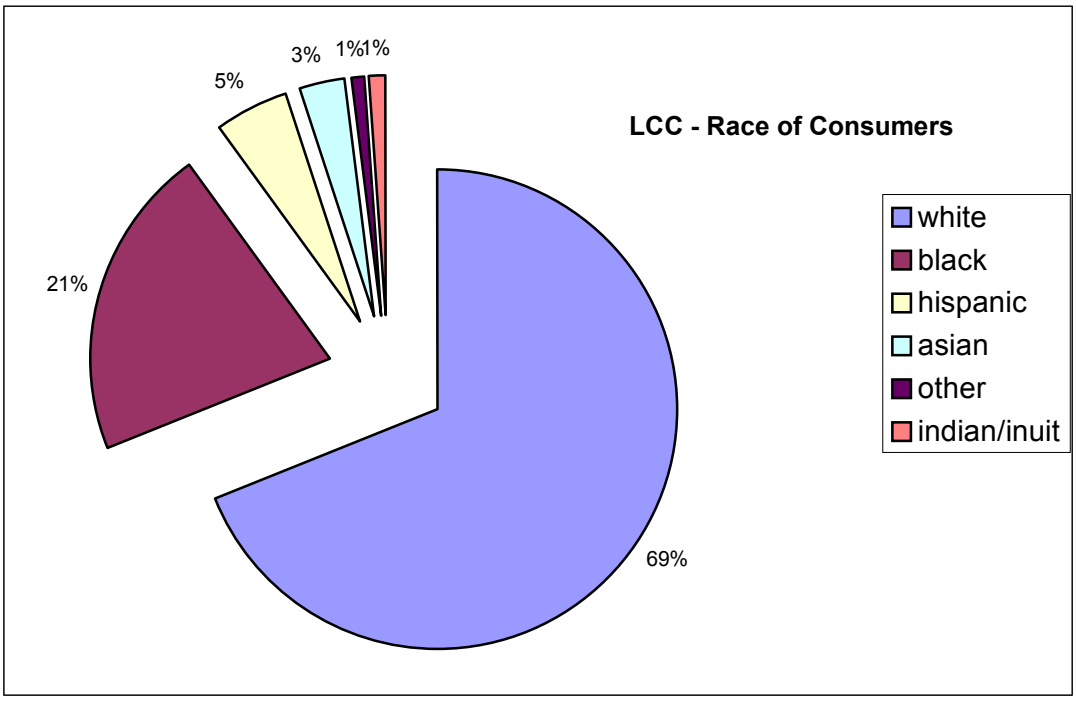
AGE: 18-30 (21%) 31-50 (61%) 51-60 (13%) 61+ (5%)



GENDER: Male (84%) Female (16%)



RACE/ETHNICITY: White (69%) Black/African Amer. (21%)
Hispanic/Latino (5%) Asian/Pac Islander (3%)
Indian/Alaskan (1%) Other (1%)



The June census was 43 with 27 diagnosed as SMI and the staffed capacity to provide services to 48 individuals (MHDS 4th Quarter, pps.16-18). Between June 00 and June 01, there was no month the census at LCC reached maximum capacity (highest was 46 – 12/00).

At the end of July 2001 there were 69 positions filled and 11 positions vacant (Agency Director's Report). Most were direct-care clinical staff (90%), with as many as twelve Forensic Specialist position vacancies (January 01).

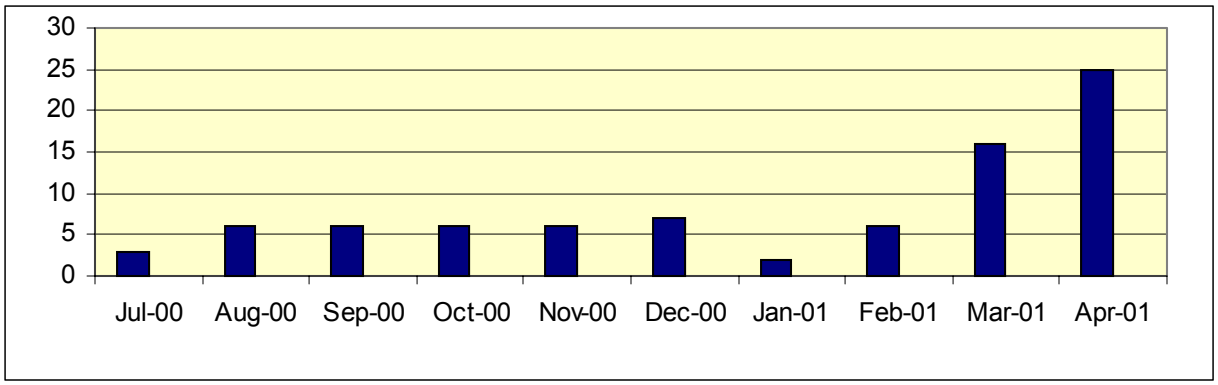
Over the last biennium, LCC has experienced increased demand for both inpatient and jail services. In January 2000 the facility increased the inpatient services to 48-beds. Over the last two years, 55% to 75% of patients at any given time are from Clark County. This means the county must transport these clients across the state for treatment. This factor suggests the state should consider building a facility in Clark County that would accommodate the population of pre-trial detainees served at LCC from the south. Data should be collected regarding the relative cost/benefit of continuing to serve southern clients in the northern facility. Request for a new 50-bed forensic facility for the Clark County area will be requested.

Jail services in the north and the south will require additional resources to be able to continue functioning at a level that meets the standard of providing services consistent with community standard. The service in Las Vegas must meet staffing levels and programming consistent with the requirements of the Department of Justice and certification by the American Correctional Association. In the north, additional clerical service is required to produce court reports in a timely manner. LCC collects $50 per evaluation to offset this cost; however, these revenues are returned to the general fund and do not afford additional transcription services to the facility. Funds should be redirected into additional support services to keep the inter-local cooperative agreement adequately functioning in a prolific and timely manner. The following spreadsheet and graph information is from Program Evaluation staff at LCC:

WASHOE COUNTY EVALUATIONS

 # Evaluations Completed

Jul-00	*3*	May-01	*26*
Aug-00	*6*	Jun-01	*28*
Sep-00	*6*	Jul-01	*36*
Oct-00	*6*	Aug-01	*31*
Nov-00	*6*	Sep-01	*18*
Dec-00	*7*	Oct-01	*19*
Jan-01	*2*	Nov-01	*22*
Feb-01	*6*	Dec-01	*14*
Mar-01	*16*	Jan-02	*17*
Apr-01	*25*		



LCC Program Evaluation also provided data regarding the Clark County detention Center. The first table is the Clark County Detention Center and the second table is the Las Vegas County Jail. The information in the various rows calculates the following:

- Bookings – total people booked into the jail for the month
- Referrals – total people referred for consultation
- SMI – of those above that were referred, the number that were severally mentally ill
- Committable – number of persons that could be committed to MHDS Inpatient
- Transferred – number of persons that are transferred to MHDS Inpatient

Apr-01	May-01	Jun-01	Jul-01	Aug-01	Sep-01	Oct-01	Nov-01	Dec-01
4479	**	4467	4611	4462	4333	4358	4125	4145
1023	856	760	893	804	971	1040	1096	1113
483	460	367	402	366	361	372	407	454
20	0	10	17	19	16	12	14	11
20	9	5	17	19	16	12	14	11

Apr-01	May-01	Jun-01	Jul-01	Aug-01	Sep-01	Oct-01	Nov-01	Dec-01
3652	**	**	3354	3318	2713	**	**	**
292	294	280	268	275	249	217	212	132
75	96	58	74	91	49	0	0	66
0	0	3	1	1	3	0	0	5
0	0	3	1	1	3	0	0	5

The facility has a growing need for adequate training opportunities. In-house training presentations from the last biennium have increased from two to fourteen. Professional staff has been sent to train out of the facility with the help of the Health Department. Additional training monies are needed for clinical staff that needs to demonstrate specialized training to their licensure boards. A twelve-hour training video was provided this biennium on assessing recidivism risk for sex offenders. The law mandates that the facility provide sex offender assessment for panels at the Department of Corrections, as well as sitting on community tier appeals. Therefore, a need for the facility is ongoing training in assessing and treating sex offenders. Staff are similarly required to remain current in all recent assessment tools for determining competency and potential for attaining competency. Risk assessment is another

important training area. In addition, all training for forensic specialists must be maintained and enhanced. These trainings are required by Nevada's Revised Statutes.
The client population at LCC is increasingly aggressive and unpredictable. The portion of the population that is hepatitis positive and HIV positive is likewise increasing. Forensic staff requires more extensive and sophisticated protective equipment to keep themselves and clients safe. Equipment is also needed to maintain a positive/negative airflow room for individuals who may be positive for TB or have other infectious airborne diseases.

The numbers of reports generated by the facility has dramatically increased. At least one more clerical staff person skilled in transcription is needed to complete the multifold increase in in-house reports. This change occurred in part because of the change in the law abolishing the Sanity Commission.

The jail facility in the South needs at least six more positions to accommodate approximately 1800 inmates in the new addition to CCDC in the spring. It is anticipated these positions would be provided for by the state, but funded by Clark County through Prison Health Systems.

The numbers of hours invested in completing sex offender panel certifications and community sex offender tier assignment appeals has consistently increased over the last year. The logistics of traveling to outlying areas such as Lovelock has also increased the cost and time of completing such panels. It seems well advised to add another half-time position to the current and hire a full-time psychologist with special skills in meeting the needs of treating and assessing sex offenders.

Lakes Crossing Center presently conducts Performance Improvement functions with an individual who is employed full time to oversee recreational therapy functions. It would make more sense to develop a position that could perform this function at least half-time and devote assistance with administrative duties such as coordinating outpatient services and admissions and discharges.

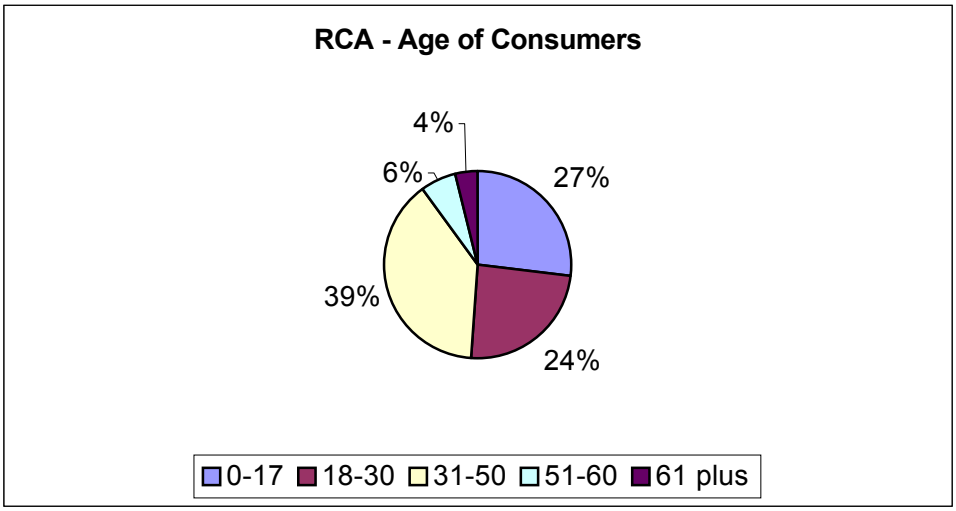
LCC needs to submit several bill drafts to assist in improving delivery of services. Among these are a bill to create certification for forensic examiners and a bill to allow the facility to petition the court for a denial of rights to refuse medication when appropriate in order to adequately treat a client toward competency.

RCA – RURAL NEVADA

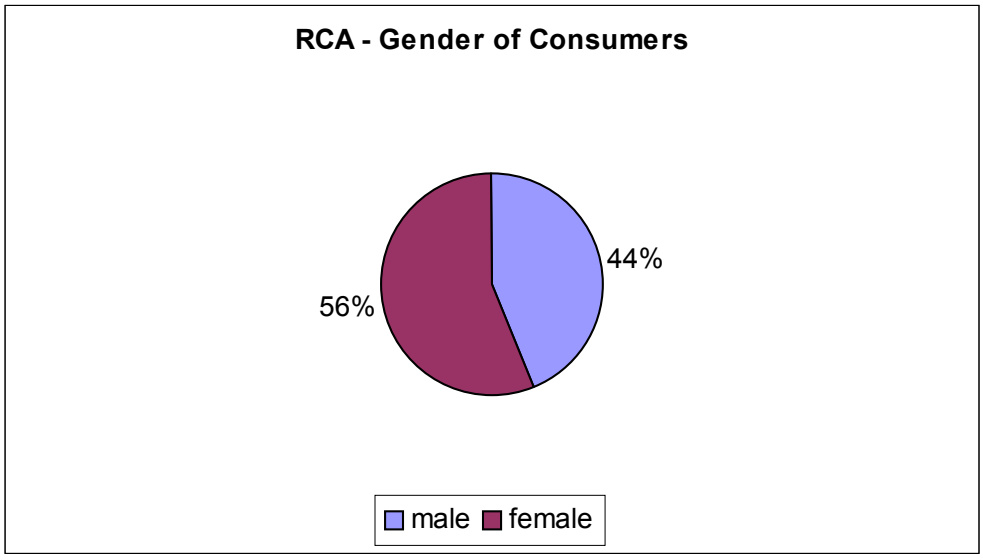
Rural Clinics Administration is responsible for operating a network of nineteen community mental health centers in the rural counties of the state (see page 30 for a list of clinics). Rural Clinics provides services to adults with SMI and children with SED (in cooperation with Division of Child and Family Services – DCFS).

As of the end of FY01, there were approximately 2,962 persons in active service in Rural Clinics across the nineteen sites. The FY01 budget was $7,174,616. The *approximate* demographic information by percentage for the population served is as follows:

AGE: 0-17 (27%) 18-30 (24%) 31-50 (39%) 51-60 (6%) 61+ (4%)

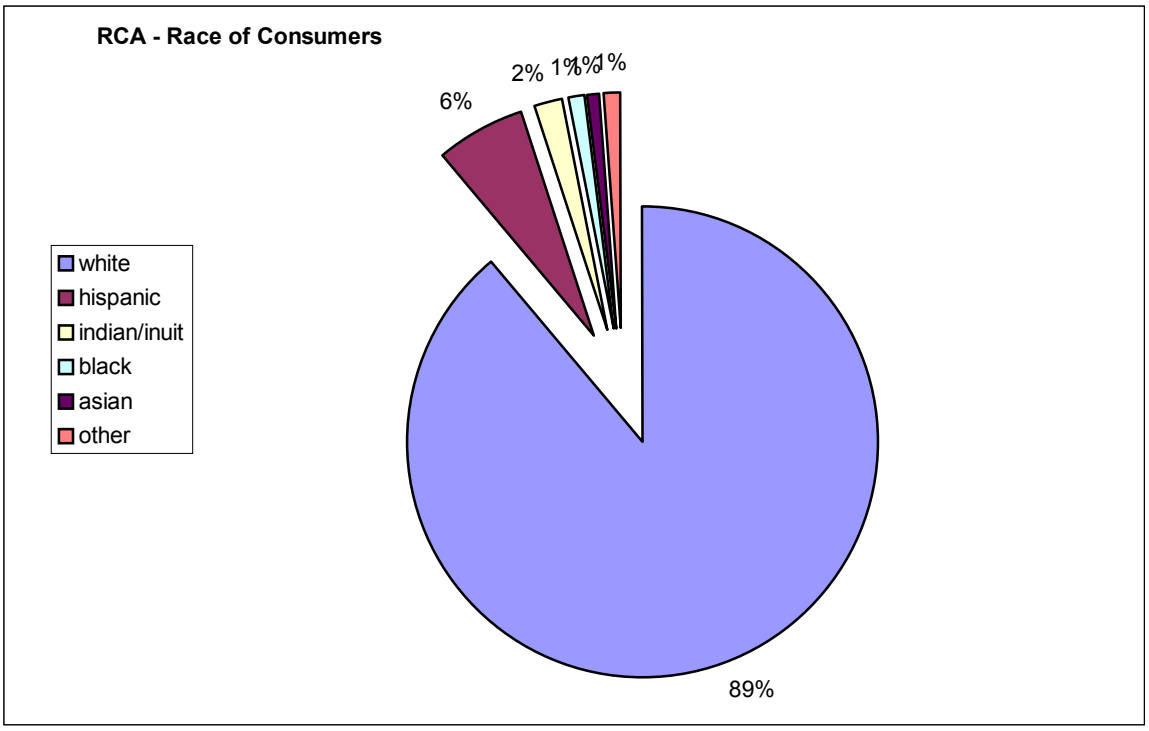


GENDER: Male (44%) Female (56%)



RACE/ETHNICITY:

White (89%)	Hispanic/Latino (6%)
Indian/Alaskan (2%)	Black/African Amer. (1%)
Asian/Pac Islander (1%)	Other (1%)



As of the end of July 2001, there were 93 positions filled and 11 positions vacant. According to Division Personnel information, the majority of vacant positions were direct-care clinical staff (75%). Rural Clinics vacancy rates are usually high (exceeding 10%) and two of the highest vacancy rates are as follows:

Clinical Social Worker 40% Clinical Program Manager 20%

Hiring and retaining qualified mental health professionals in rural Nevada is on ongoing issue. The current wait list in the various clinics would be eliminated if all positions were filled. Additional financial incentives for interviewing and moving expenses will increase the likelihood of hiring qualified persons. Rural Clinics currently offers reimbursement of reimbursement of interview and moving expenses for Elko, Winnemucca, and Ely offices, but this money is taken from existing budgets. There is a need for a specific budget account for this area.

The various programs provided by Rural Clinics are:

Outpatient Counseling	Medication Clinic	Residential Supports
Service Coordination	Psychosocial Rehabilitation	Emergency Services
Consultation and Education		

NOTE: Rural Clinics does provide emergency services in sixteen of the nineteen clinics on a 24-hour, 7 day a week basis. Outpatient counselors, who provide counseling during regular work hours, provide this service. The recommendation by Rural Clinics Administration is to look at the definition of emergency services, as currently it is defined as "PES" and, if the definition is changed, to include these data in monthly reports sent to Division. Additionally, Rural Clinics does not have a specialized service for the elderly; however, services are provided to elderly persons without discrimination. This size of the clinics simply does not allow a specialty program for different age groups.

PROGRAMS/SERVICES DATA

OUTPATIENT COUNSELING: Provided on an individual, family and group basis. These services may include diagnosis and evaluation, counseling, psychotherapy, and behavioral management for the purpose of producing cognitive/behavioral change, improving decision-making, reducing stress, and preventing hospitalization.

The June 2001 census was 2,962 with approximately 1,357 diagnosed as SMI (MHDS 4th Quarter, p.26). The gaps analysis indicated there was an unmet need/gap throughout the rural areas of approximately 5,805 and, therefore, this service was a "high priority" (Needs Assessment Survey).

MEDICATION CLINIC: Provided by a psychiatrist or advanced practice nurse with prescriptive privileges to evaluate, prescribe and monitor medications for the treatment of psychiatric disorders. Services include limited and focused consumer consultation about medication treatment and referrals to other agencies. Persons admitted to the Medication Clinic also participate in one or more additional services (e.g., counseling, Psychosocial Rehabilitation (PSR), or Service Coordination). Thus, the concept of "unduplicated" counts is not applicable to Medication Clinic. Indeed, the same holds true for Service Coordination and PSR. The gaps analysis indicated there was an unmet need/gap in the rural areas of approximately 14,291 (throughout rural Nevada) and, therefore, this service was also a "high priority" (Needs Assessment Survey).

RESIDENTIAL SUPPORTS: Provides Supported Living Arrangement and Shelter Plus Care to best meet the needs and the goals of the individual and/or family. As of the end of FY01 the active caseload was 39 of which 31 were diagnosed as SMI (MHDS 4th Quarter, p.30). The Needs Assessment Survey indicated that there was an unmet need/gap of 718 in the rural areas and that therefore this service was a "high priority".

Residential supports remains a deficiency in rural Nevada, as shown by these data. Rural Clinics infrastructure requires strengthening in this area to approximate the need – at least double the number of units.

PSYCHOSOCIAL REHABILITATION: Assists clients in education, employment, social relationships, living situations, leisure lifestyle, and wellness. Service are designed to teach and reinforce functional, adaptive, independent living, social and vocational skills with an emphasis on preparing for and maintaining employment or other self-fulfilling, productive activities.

Service Coordinators work closely with the Bureau of Vocational Rehabilitation when working on job skills and work attainment.

The June 2001 census was 86 and all were diagnosed as SMI. The Needs Assessment Survey indicated there were an unmet need/gap of 2,243 for vocational services (high priority) and an unmet need/gap of 450 for "Activities of Daily Living Skills" training (medium priority).

SERVICE COORDINATION: Provides coordination of treatment by assisting consumers to access needed services/programs, such as various programs and groups, housing, financial, medical, employment, social, transportation, crisis intervention, entitlement programs (food stamps, SSI, etc.) and other essential community services/programs. Service Coordinators also help mobilize family, community and self-help groups on behalf of the consumer.

The June 2001 census was 1,243 persons and 1,048 were diagnosed as SMI. The Needs Assessment Survey indicated there was an unmet need/gap of 660 in the rural areas and, therefore, this was a "high priority."

CONSULTATION AND EDUCATION: Rural Clinics is the only mental health agency in many rural counties. Thus, in the spirit of community-based mental health, staff provides consultation and education services to a variety of agencies, including jails, schools, Head Start, Juvenile Probation, albeit on a limited basis.

Table 10 below provides a breakdown of program evaluation data by clinic (19 agency total) as of the end of June 2001:

Clinics	Active Cases (SMI)	Total Admission (SMI/SED)	Average Monthly
Carson	512	296	530
Douglas	365	392	401
Ely	109	186	125
Elko	159	105	121
Fallon	196	198	214
Hawthorne	69	46	74
Tonopah	28	29	20
Winnemucca	213	176	190
Battle Mountain	71	60	91
Lovelock	46	48	50
Yerington	305	132	316
Dayton	140	84	121
Silver Springs	161	152	144
Fernley	137	93	117
Mesquite	163	129	127
Overton	25	33	17
Pahrump	253	255	245
South Lake Tahoe	10	10	13
Wendover	0	0	0
TOTAL	**2962**	**2424**	**2916**

As can be seen from the table on the previous page, Carson has the highest active caseload (N=512). Douglas (N=365) and Yerington (N=305) also have high active caseloads.

Attachment V is a Needs Assessment for both the Laughlin and South Lake Tahoe areas that were conducted by Rural Clinics Administration staff in 1999. The report for Laughlin indicates that the area is an isolated community with a demonstrated need for mental health services. The report on South Lake Tahoe indicates that a clinic, which was closed in 1992, needs to be reopened due to the gap in mental health services and the weather and distance that pose a problem for those consumers who are in need of services but have to travel to the Minden office.

Rural Clinics has converted several "clinical" positions to nurse positions over the last two years in order to properly staff the Medication Clinics in nine of the offices. In addition, several new service coordination positions were added during the last legislative session.

Additional infrastructure strengthening is needed in the following areas: Psychiatric time increased to meet the demands of the Medication Clinic caseloads, increase in medication budget to insure a secure resource (Rural Clinics currently gets approximately two-thirds of the medication needed through donations in the form of scholarships and sample medications.

As noted above, the Residential Services program will require a significant increase in funding in order to approximate meeting the need shown by this Needs Assessment. An Intensive Supported Living Arrangement program is needed for Developmental Services and Rural Clinics in Elko, which will serve Elko, White Pine, Eureka, Lander and Humboldt Counties. This will reduce the need for costly inpatient treatment and costly transportation costs in order to transport persons to the urban areas in Washoe and Clark Counties.

Rural Clinics has a training budget of approximately $9,000.00 per year. In order to keep abreast of program and clinical changes and advances, this budget could easily be quadrupled. Rural Clinics does not have a staff person dedicated to Performance Improvement (PI), as do our sister agencies of SNAMHS and NNAMHS. The person currently responsible for PI is also responsible for overseeing five main clinics, as well as serving as the agency training coordinator. Clearly, Rural Clinics requires at least one FTE to serve as the PI and training coordinator. Additionally, this position would require a half-time (.5 FTE) support staff. If this person is funded, then Rural Clinics could seek accreditation from either "CARF" or the "Council", which currently accredits Developmental Services within MHDS (since Rural Clinics is more like Developmental Services in the community-based services domain). As initial estimate of cost for accreditation is $140,00.00 per year, including the personnel noted above.

Mental illness and substance abuse (co-occurring disorders) – Rural Clinics currently provides limited services in Pahrump, Tonopah, Mesquite (and Ely when we can recruit a person) through a $202,000.00 grant from the Bureau of Alcohol and Drug Abuse. Given the prevalence of co-occurrence of these two problems (up to 60-75% in inpatient clients), Nevada would do well to increase funding for services in or near home communities.

QUALITY ASSURANCE/PERFORMANCE IMPROVEMENT

Performance Improvement (PI, AKA Quality Assurance or QA) exists at both the agency (full or part-time) and Division levels to monitor the quality of both inpatient and outpatient services. Currently there are four full-time PI staff, two at the Division office, one at NNAMHS and one at SNAMHS. Rural Clinics Administration and Lake's Crossing Center have staff who are dedicated to conduct PI staff only on a part-time basis. Please see the recommendations regarding accreditation and performance improvement in the Division Central Office section of this report.

The PI process is based upon the following goals:

- Improve the quality of services provided to Nevadans who require mental health services
- Improve the work environment of employees
- Provide legislative and statewide accountability
- Ensure that agencies meet community and industry standards

The mission of Performance Improvement is to implement a process that evaluates organizations based on adopted standards. The process involves all stakeholders and guides agencies to meet the needs of the mental health community. The purpose of PI is the overall improvement of services including the efficiency, effectiveness, and availability of resources. The process is integrated throughout all aspects of day-to-day service delivery. Performance Improvement is a continuous, positive, process-oriented program that provides technical support and education. The process is driven by the following values:

- A non-static concept of quality
- Efficiency in resource allocation
- Staff empowerment in organizational improvement activities
- Staff and their contributions
- Community input
- Diversity
- Positive reinforcement
- Adherence to the Division MHDS Strategic Plan

According to the PI Primer (currently being revised), the PI team is responsible for ensuring the quality of services provided to consumers who seek outpatient, community-based services throughout the year. These services are provided at agencies within the Division or at agencies that contract with the Division to provide services to consumers. Types of services include, but are not limited to:

Medication Clinic	Outpatient Counseling	Service Coordination
Residential Supports	Geriatric Services	Psychosocial Rehabilitation
Forensic Services	Programs for Assertive Community Treatment (PACT)	

From July 1, 2000 to June 30, 2001, approximately 10 programs were reviewed for compliance to adopted clinical standards in the following categories:

☼ Assessment ☼ Consumer Rights ☼ Treatment Planning ☼ Medication Clinic
☼ Record Format ☼ Progress Notes ☼ Service Coordination

Performance improvement monitors compliance levels in these areas of clinical care with a required compliance rate of 80%. The areas of clinical documentation that were most frequently cited *as needing improvement* (less than 80%) statewide include:

☼ Presenting problem ☼ Psychiatric history ☼ Medical history
☼ Consumer strengths ☼ DSM-IV, axes 1-5 ☼ Prob. list/TX plan
☼ Treatment goals ☼ Interventions ☼ Responsible staff
☼ Measurable objectives ☼ Address/defer ☼ 90-day review
☼ Individualization ☼ Review in notes ☼ Reflect plan/needs
☼ No loose filing ☼ No blanks ☼ Corrections
☼ Physician signature ☼ Medication consent

Agency programs were similarly reviewed for compliance regarding Administration and Environment of Care include the following areas:

Administration	Environment of Care
Administrative Controls	Environmental/Safety Controls
Knowledge Resources	Environmental Appearance
Communications Resources	Access

Administrative and Environmental reviews and staff surveys indicated that the following areas needed improvement:

- ❖ Information resources
- ❖ Staff orientation and training
- ❖ Communication resources (e.g., voice mail, E-mail, LAN, AIMS)
- ❖ Fire drill and fire extinguisher information and records
- ❖ Mental health and community resource information

The Division also conducted a consumer[10] survey since the last Needs Assessment. A copy of this report can be obtained by calling the Division of MHDS (775-684-5943). Questions which consumers most frequently disagreement with include:

- ❖ If I had other options, I would still choose to get services from this agency
- ❖ Staff returned my calls within 24 hours
- ❖ I was able to see a mental health specialist when I wanted to
- ❖ I was able to get services I thought I needed
- ❖ I felt free to complain
- ❖ Staff was sensitive to my cultural/ethnic background
- ❖ I was encouraged to use consumer-run programs
- ❖ Staff respected my wishes about who is and is not to be given information about my treatment

[10] Division MHDS Report on Consumer Satisfaction Survey (May 2000).

When consumers were asked about improving services they responded:

- More time with service provider
- Less waiting time
- Extended hours of service
- Hotline for consumers
- Direct link to employment
- Spanish speaking staff
- Better communication between inpatient and outpatient
- Shorter waiting time for appointments
- Less staff turnover

The Division also conducted a staff[11] survey. A copy of that report can be obtained by calling the Division of MHDS (775-684-5943). Questions that staff most frequently disagreed with include:

- Consumers, not staff, decide services goals
- Consumers concerns are solicited and addressed
- Consumers are given information they needs to take charge of their lives
- I receive adequate orientation and training
- Personnel issues were fully explained to me
- Adequate orientation to new policy exists at my agency
- The agency peer review process is useful

When staff people were asked about what improvements they felt were necessary, they responded:

- Additional staff (or lower caseloads)
- Additional resources (e.g., computers, copy machines, training, etc.)
- Additional vehicles
- Communication (top-down and vice versa)
- Funding
- Paperwork (streamline or less)

The Division of MHDS Training Committee also conducted a "Training Needs Assessment" (Williams, 2001) survey in consultation with the Behavior Analysis Program at the University of Nevada, Reno (UNR). The survey had the following four categories of training topics to rate:

- Assessment/Treatment
- Operations/Systems
- Disorders
- Theories

The majority of staff at all six agencies, four of which were mental health agencies, ranked the Assessment/Treatment category as the most important training category overall. Within that category, the majority of staff ranked *best practice*, *behavioral treatment and assessment*, *procedures*, and *tools* as the most important training topics.

[11] Division of MHDS Staff Survey Report (February 2000).

During the last Needs Assessment the following Division-specific issues were noted:

- Maintaining an interactive web site
- Maintaining a disaster response plan
- Measuring consumer satisfaction
- Funding for PI purposes

With the exception of additional office space and conference room for staff, the division-specific issues have been accomplished. Please note the division web address of www.mhds.state.nv.us.

COMMUNITY HOMELESS INFORMATION

The Division of MHDS is committed to serve persons with mental illness. This includes, within budgetary constraints, those persons (individuals and families) who are homeless. The Division Administrator has been working with a "Policy Academy for Homeless Families with Children", which indicates that government and private programs will work together to encourage, facilitate and fund services tailored to the needs of those people who are homeless and suffer from a serious mental illness. Division staff also works with non-profit homeless assistance service providers regarding other homeless assistance programs.

Most of these providers conduct intake, assessment, and a variety of other services to people who are seeking such services from their agency. In addition, these providers may also refer consumers to other agencies within the community. Some of these providers also participate in local "Continuum of Care (CoC)" efforts. As of part of the CoC process, each geographical area must do a "needs/gaps" analysis. The tables on the following pages provide information about the current inventory of services, unmet need/gap and the priority of that service/program for each geographical area. They are presented as they relate to individuals and families who are homeless and are defined within a certain subpopulation (e.g., serious mental illness, co-occurring disorder, domestic violence, etc.).

NOTE: The U.S. Census Bureau (www.census.gov website 10/01) released a report on the population within emergency and transitional shelters within Reno and Las Vegas. The count **ONLY** includes emergency shelters (with sleeping facilities), shelters for children who are runaways, neglected or without conventional housing, hotels and motels and does **NOT INCLUDE** information from shelters against domestic violence. In 2000, there were a total of 1,553 people in shelters. This is separated as follows (approximate numbers):

Gender/Age	Male	Female	Total
Under 18 years	99	89	188
Over 18 years	1,059	306	1,365
Total	1,158	395	1,553

Age by area	Under 18	Over 18 years	Total
Reno	48	195	243
Las Vegas	140	1,170	1,310
Total	188	1,365	1,553

The Census Bureau stressed the shelter figures do not constitute and should not be construed as a tabulation of the total population without conventional housing or "people experiencing homelessness."

CLARK COUNTY:

Due to a recent homeless study done in Las Vegas that estimated the number of homeless people at approximately 7,000, members of the Southern Nevada CoC requested $4 million dollars of HUD monies to address the community's needs for homeless services. The projects submitted in the 2001 application serve homeless populations documented to be of critical need in the HUD Consolidated Plan (please see your local Commission on Economic Development for information). The application reflects an inclusive process fair and equitable in the allocation of resources for existing programs, the initiation of new programs, and is also based on needs/gaps deemed "high-priority" by all members involved in the CoC. The Clark County CoC needs/gaps analysis is as follows:

Individuals		Estimated Need	Current Inventory	Unmet Need/Gap	Relative Priority
Beds/Units	Emergency Shelter	2,602	671	1,931	M
	Transitional Housing	1,945	1,339	606	L
	Permanent Housing	891	199	692	H
	Total	5,438	2,209	3,229	
Estimated Supportive Services Slots	Job Training	1,135	679	456	L
	Service Coordination	4,993	1,339	3,654	H
	Substance Treatment	1,067	239	828	H
	Mental Health Care	1,855	441	1,414	H
	Housing Placement	4,547	1,339	3,208	H
	Life Skills Training	4,547	1,675	2,873	H
	Domestic Violence	No info	No info	No info	No info
	Shelter	52	12	40	H
	Educational Services	1,494	25	1,469	H
Estimated Subpopulations	Substance Use Disorder	1.067	399	668	M
	Seriously Mentally Ill	963	441	522	H
	Co-Occurring Disorder	893	0	893	H
	Veterans	908	135	773	H
	HIV/AIDS	780	32	748	H
	Victims of Domestic Violence	52	12	40	H
	Unaccompanied Youth	1,000	85	915	H
	Gambling Addiction	217	119	98	L
	Physically Disabled	653	0	653	H
	Seniors	161	40	121	M
	Service-Resistant	734	20	714	H

Persons in Families with Children		Estimated Need	Current Inventory	Unmet Need/Gap	Relative Priority
Beds/Units	Emergency Shelter	610	541	69	No Need
	Transitional Housing	456	367	89	L
	Permanent Housing	209	185	24	H
	Total	1,276	1,093	183	
Estimated Supportive Services Slots	Job Training	266	0	266	H
	Service Coordination	509	381	128	L
	Child Care	114	3	111	H
	Substance Abuse Treatment	227	10	217	H
	Mental Health Care	395	0	395	H
	Housing Assistance	1,067	499	568	M
	Life Skills Training	1,067	533	534	M
	Domestic Violence	230	106	123	H
	Educational Services	350	119	231	H
Estimated Subpopulations	Substance Use Disorder	227	77	150	M
	Seriously Mentally Ill	205	77	128	M
	Co-Occurring Disorder	190	0	190	H
	Veterans	193	0	193	H
	HIV/AIDS	193	0	183	H
	Victims of Domestic Violence	230	106	123	M
	Gambling Addiction	94	40	54	M

Because of the needs/gaps in service, the Southern Nevada Continuum of Care application prioritized the following programs/services:

1. Southern Nevada Adult Mental Health Services (SNAMHS) – Shelter Plus Care
2. Women's Development Center (WDC) – Transitional/Supportive Housing Program
3. Women's Development Center (WDC) – Transitional/Supportive Housing Program
4. St. Vincent/HELP – Transitional/Supportive Housing Program
5. St. Vincent/HELP – Transitional/Supportive Housing Program
6. Salvation Army – Transitional/Supportive Housing Program
7. The Shade Tree Shelter – Emergency/Transitional Program
8. US Vets – Permanent Supportive Housing
9. Mojave Mental Health – Permanent Supportive Housing

It is not guaranteed all units or programs/services will be funded by the federal source (HUD), as this is a competitive grant. The providers, number of units requested and/or persons to be served, and estimated funding (if request obtained in total) is as follows:

Program	Units and/or Persons Served	Federal (grant)	State (general and/or Medicaid)	In-kind/other
SNAMHS	82	$404,367	$348,722	$748,008
WDC	8	$146,212.50	None	$60,970.34
WDC	7	$262,042.52	None	$117,689.28
St. Vin/HELP	66	$447,400	None	$149,134
St. Vin/HELP	54	$384,054	None	$122,018
Salvation Army	330	$486,320	None	$267,989
Shade Tree	656	$605,830	None	$159,000
US Vets	5	$500,000	None	$618,556
Mojave	25	$380,000	$211,950	$22,500
TOTAL	1,233	$3,616,226.02	$560,672	$2,265,864.62

NOTE: Not all funds were obtained for these units and/or persons served.

WASHOE COUNTY:

The Reno Area Alliance for the Homeless (RAAH) is responsible for the development of the CoC process that affects persons (individuals and families) who are homeless within Reno, Sparks, and Washoe County. RAAH members include homeless service providers, substance abuse treatment providers, public and private medical service providers, etc. All emergency shelters in Washoe County gathered information. Information was gathered using "point in time" data to determine need, inventory, unmet need/gap, and to prioritize funding for service providers and projects needed to meet the needs of people who are homeless and are defined within a certain subpopulation in Washoe county. The Washoe County needs/gaps analysis is located on the following page:

Individuals		Estimated Need	Current Inventory	Unmet Need/Gap	Relative Priority
Beds/Units	Emergency Shelter	331	256	75	L
	Transitional Housing	712	544	168	M
	Permanent Housing	406	174	232	H
	Total	1,449	974	475	
Estimated Supportive Services Slots	Job Training	415	120	295	H
	Service Coordination	1,262	747	515	L
	Substance Abuse Treatment	416	146	270	H
	Mental Health Care	924	467	457	M
	Housing Assistance	255	116	139	M
	Life Skills Training	621	318	303	M
	Outreach	299	117	182	H
	Basic Need	937	495	442	L
Estimated Subpopulations	Substance Use Disorder	3,565	2,088	1,477	M
	Seriously Mentally Ill	732	350	382	H
	Co-Occurring Disorder	284	167	117	M
	Veterans	1,587	939	648	M
	HIV/AIDS	28	17	11	L
	Victims of Domestic Violence	71	42	29	M
	Youth	128	58	70	H
	General Population	1,283	768	515	L

Persons in Families with Children		Estimated Need	Current Inventory	Unmet Need/Gap	Relative Priority
Beds/Units	Emergency Shelter	132	74	58	M
	Transitional Housing	284	232	52	L
	Permanent Housing	162	87	75	H
	Total	578	393	185	
Estimated Supportive Services Slots	Job Training	166	48	118	H
	Service Coordination	505	298	207	L
	Substance Abuse Treatment	166	59	107	H
	Mental Health Care	370	187	183	L
	Housing Placement	102	46	56	M
	Life Skills Training	248	127	121	L
	Outreach	120	47	73	H
	Basic Need	469	198	271	M
Estimated Subpopulations	Substance Use Disorder	1,426	835	591	M
	Severally Mentally Ill	293	140	153	H
	Co-Occurring Disorder	113	67	46	M
	Veterans	635	372	263	M
	HIV/AIDS	11	7	4	L
	Victims of Domestic Violence	50	35	15	L
	Youth	51	23	28	H
	General Population	513	307	206	L

Because of the need noted in the two tables above, the Truckee Meadows Continuum of Care sought HUD funds for ReStart, a non-profit organization, to provide community outreach and transitional housing for individuals and families at four separate housing locations in the community. ReStart works closely with Northern Nevada Adult Mental Health Services as well as other supportive service providers to meet this need in the community.

RURAL NEVADA:

Rural Clinics Administration, Nevada Rural Housing Authority, and other social service agencies that have responsibilities throughout rural Nevada form the core group (Steering Committee) of entities that make up the Rural Nevada Continuum of Care (RNCOC). The Steering Committee, along with members of each community that assists persons (individuals and families) who are homeless, participates in the CoC process and prioritizes how best to meet the needs of people that are homeless within the 96,000 square miles that represents rural Nevada. The RNCOC Steering Committee has been in existence for approximately five years and has yet to receive funding from HUD for any of the projects submitted in the CoC applications. The tables below are the data collected from the 2001 RNCOC application:

Individuals		Estimated Need	Current Inventory	Unmet Need/Gap	Relative Priority
Beds/Units	Emergency Shelter	1,500	825	675	L
	Transitional Housing	1,500	200	1,300	M
	Permanent Housing	1,700	200	1,500	H
	Total	4,700	1,225	3,475	

Individuals		Estimated Need	Current Inventory	Unmet Need/Gap	Relative Priority
Estimated Supportive Services Slots	Job Training	2,519	1,159	1,360	M
	Service Coordination	4,739	1,964	2,775	H
	Substance Abuse Treatment	2,684	1,299	1,364	H
	Mental Health Care	3,873	2,238	1,635	H
	Housing Placement	28	14	4	L
	Life Skills Training	994	344	650	L
	Transportation Services	1,004	709	295	L
	Medical/Dental Care	3,440	1,945	1,495	H
	Housing Assistance	3,132	946	2,186	H
	Educational Services	55	40	15	L
	Legal Assistance	513	11	502	L
	Veterans Services	108	78	30	L
Estimated Subpopulations	Substance Use Disorder	1,997	1,492	475	M
	Severally Mentally Ill	5,677	4,282	1,385	H
	Co-Occurring Disorder	3,426	3,287	390	M
	Veterans	96	85	11	L
	HIV/AIDS	156	117	49	L
	Victims of Domestic Violence	991	481	510	M
	Youth	1,225	1,128	87	L
	General Population	581	545	36	L

Persons in Families with Children		Estimated Need	Current Inventory	Unmet Need/Gap	Relative Priority
Beds/Units	Emergency Shelter	1,758	1,618	140	L
	Transitional Housing	400	50	350	M
	Permanent Housing	450	50	400	H
	Total	2,608	1,718	890	
Estimated Supportive Services Slots	Job Training/Life Skills	1342	432	882	M
	Service Coordination	1,466	904	562	M
	Substance Abuse Treatment	1,549	964	585	M
	Mental Health Care	1,242	563	679	M
	Transportation Services	432	399	93	L
	Medical/Dental Care	1,399	47	1,352	H
	Housing Assistance	1,301	881	420	L
	Family Support Services	1,061	223	838	H
	Legal Assistance	525	100	425	M
	Veterans Services	60	30	30	L
	Domestic Violence Services	1,442	630	812	H
	Educational Services	2,105	1,498	607	M
Estimated Subpopulations	Substance Use Disorder	1,775	425	1,350	M
	Severally Mentally Ill	2,975	338	2,638	H
	Co-Occurring Disorder	2,445	331	2,114	H
	Veterans	41	25	16	L
	HIV/AIDS	1	1	0	L
	Victims of Domestic Violence	1,489	337	1,157	H
	Youth	0	0	0	L
	General Population	1,090	810	280	L

Because of the need for permanent supportive housing as well as a variety of other services needed in the rural areas, Rural Clinics Administration requested HUD Continuum of Care funding to increase capacity in the rural areas (Shelter Plus Care). HUD did not fund the application, however, the RNCOC Steering Committee is continuing to work on the CoC process and will continue to seek funding.

DISCUSSION

As indicated throughout this report, the needs of consumers are as unique as the various urban and rural geographical areas. In order to meet the diverse needs of all consumers of mental health services, the following issues should be addressed with specific programmatic and budgetary recommendations:

- Infrastructure gaps within the Division of MHDS include:
  - Policy planning capacity
  - Training
  - Accreditation
  - Management of Information
  - Disaster response
  - Statewide peer counselor program
  - Statewide coordination of programs that assist consumers who are homeless

- Expansion of community-based mental health services, noted as a high priority by the various agencies within the Division of MHDS, for those persons (adults and children) who have a serious mental illness (including co-occurring substance use disorder). Services indicated as high priorities need to be addressed. As the end of last year, approximately 9,500 homeless/indigent people per year received outreach services. Due to waiting lists, as well as other service barriers, only 1-2% actually received services. The reasons for this may be due to management of information issues, however, homeless service providers and advocates have indicated that availability and accessibility remain the most common barriers to services.

- Advocates/Agencies should work together to develop and fund specific programs and services targeted to individuals and families who are homeless/indigent.

- Agencies should also work with the Division of MHDS to develop strategies regarding needs that are not service specific such as:
  - The cultural variations within their communities
  - Staff vacancy rates
  - Waiting lists
  - Specific training needs of staff
  - Specific infrastructure needs at agency level

- In order to address the issues of fragmentation, accessibility and availability, the Division and its advocates should work in concert to develop a statewide service directory or information clearinghouse that both staff and consumers can access to find out information about agencies, the services the provide, days and hours of operation, etc. Attachment VI contains a copy of various services provided in Fallon. This is a good example of the type of information needed for the directory.